

Textbook on Evidence-Based Holistic Mind-Body Medicine

Sexology and Traditional
Hippocratic Medicine

SØREN VENTEGODT
JOAV MERRICK

Health and
Human Development
Joav Merrick
(Series Editor)

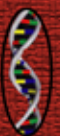
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HEALTH AND HUMAN DEVELOPMENT

**TEXTBOOK ON EVIDENCE-BASED
HOLISTIC MIND-BODY MEDICINE**

**SEXOLOGY AND TRADITIONAL
HIPPOCRATIC MEDICINE**

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Additional color graphics may be available in the e-book version of this book.

Library of Congress Cataloging-in-Publication Data

ISBN: ; 9: /3/84479/398/7 (eBook)

Library of Congress Control Number: 2012939744

Published by Nova Science Publishers, Inc. † New York

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Contents

Preface		xiii
Introduction		xv
Section 1: Holistic sexology: Healing character and existence		1
Chapter I	The Oedipus complex	3
Chapter II	Problems with sex and living together	7
Chapter III	Psychodynamic therapy - and beyond	17
Chapter IV	Sexuality and existential problems	21
Chapter V	Sex and Viagra – An introduction to the paradigms of sexology	23
Chapter VI	The life mission theory revisited - Understanding existential healing in sexology	37
Chapter VII	Sexuality and quality of life in Denmark	41
Chapter VIII	Traumatic life events and later quality of life	53
Chapter IX	Female sexual problems and quality of life	67
Chapter X	Effect of vaginal acupressure (hippocratic pelvic massage)	79
Chapter XI	Teaching orgasm for females with chronic anorgasmia using the Betty Dodson Method	99
Chapter XII	Impaired self-rated ability of functioning sexually improved by psychodynamic short-term therapy complemented with bodywork	115
Chapter XIII	The holistic view of the adolescent's sexual development	123
Chapter XIV	Eating disorders	129
Chapter XV	How to counsel and treat young people to alleviate and prevent sexual problems	147
Chapter XVI	Psychosomatic reasons for chronic pain	159

Chapter XVII	Pain and pleasure in sexuality	163
Chapter XVIII	Genital, sexual and non-sexual pain and other health problems related to the female gender	187
Chapter XIX	How to avoid the Freudian trap of sexual transference and counter transference	209
Chapter XX	How to use implanted memories of incest as a tool for dissolving a strong female Oedipus complex	225
Chapter XXI	Holistic approach to rape and incest trauma	231
Chapter XXII	Long term effect of child sexual abuse and incest with a treatment approach	243
Chapter XXIII	Patient diary as a tool in the treatment	257
Chapter XXIV	Rehabilitation of philosophy of life during holistic existential therapy for childhood sexual abuse	291
Section 2. Acknowledgments		303
Chapter XXV	About the authors	305
Chapter XXVI	International review board	307
Chapter XXVII	About the Quality of Life Research Center in Copenhagen, Denmark	309
Chapter XXVIII	About the National Institute of Child Health and Human Development in Israel	315
Section 3. Index		319
Index		321

Preface

Holistic medicine, or quality of life as medicine, as we often call it, is basically a strategy for improving the patient's quality of life through mobilizing of inner resources. This can never harm and will almost always benefit the patient's well-being and often also help him or her to fight back the disease. The cure or intervention is very much the same for all patients irrespective of the diagnosis: The therapist must help the patient to know him- or herself better, to step into character and be more yourself, and more in tune with the universe. So the intervention can start right away, also without a specific diagnosis. Is modern, holistic medicine powerful? Oh yes, very much so. Holistic medicine is a truly powerful medicine, in spite of the lack of really understanding the deepest structures of consciousness, the connection between mind and body and the way holistic medicine works. But just because our scientific understanding is limited, we should not stop doing what we know works. In this book the authors cover sexology in the traditional Hippocratic medicine from a new and modern scientific approach.

Introduction

Sex is a difficult subject. When sexuality appears in our consciousness it often has a distinct and remarkable quality, very different from love. Sexuality is often described with concepts from the animal world. It is considered the most primitive and undeveloped side of man. It is something that needs to be controlled and developed. Sex is rarely just accepted as it is. We rarely embrace our sexuality and accept it as a natural part of us.

Sex is normally between yourself and your partner and a mostly private thing. Many therapists sometimes find it extraordinarily difficult to deal with sexuality in the clinical setting. If a patient gets aroused, or if you do, when being with a patient, it is often seen as an error, something that is not supposed to happen. We then try to repress it and control it. Unfortunately this will not make sex go away. It will only make its quality dark, forbidden, shameful and sinister. So this is not the right way to go about it. Do not act out sexually in the clinic, but do not repress your feelings either. Feel what you feel. You feel that for a reason. This is our approach to sexology.

Sexology

Sexology, the art and science of helping other people with their sexual problems, has been an integrated part of every culture as long as we have recordings. In India, China, Japan, Tibet and most other Buddhist countries, we have the tradition of tantra working directly for sexual healing (1,2). In Europe we have the Hippocratic tradition of sexology, used for healing hysteria and other mental illnesses, which in old Greece was understood as disorders so closely related to sexuality that only a sexological treatment could cure them (3). We have sources of sufficient quality to know for sure that the old Hippocratic sexological manual procedures have been in intensive use by physicians for more than 2000 years (4-10).

About the year 1950, when today's medical science was developed, a significant interest among physicians also led to the development of a scientific sexology; Kinsey used to praise the sexologists of the 18th century for their almost-perfect physiological description of the human coitus (11), and he claimed that only little was added to this basic understanding during the next century. Interestingly the originally holistic sexological therapy, using both talking and touching for healing, developed into either talk therapy or touch therapy during the 20th century. Sigmund Freud (1856–1939) and the psychoanalytic tradition used massage

in the holistic tradition in the beginning (12), but abandoned this presumably to be more acceptable in society (13). Wilhelm Reich (1897–1957) found that this development seriously failed the patients as fewer were helped and returned to sexological bodywork, but suffered from all the political problems Freud managed to avoid (14,15). Hoch, Fithian, Pomeroy, Brown, Graber, Kline-Graber, Kegel, Grafenberg and many more sexological researchers (16-27) used the original manual sexological procedures, but adjusted them to the needs of the modern patient and developed the educational “sexological examination.” Since then physical therapy for the pelvic floor has been shown to be efficient for a number of female disorders in about 50 randomized clinical trials and many more uncontrolled clinical interventions (28-45), and the sexological procedures have been used to cure many different clinical problems, from vulval pain and vulvodynia to infertility (46).

Holistic sexology is aiming to integrate all the knowledge and tools of the different traditions for Reichian therapy, sexology and pelvic physiotherapy. The psychodynamic aspects from psychoanalysis can be very helpful for the patient (47-51) and so can the energetic and spiritual wisdom from Tantra and the oriental traditions (1).

The practice of holistic sexology consists of therapeutic conversation and manual sexological therapy, often called “vaginal massage,” “vaginal acupressure,” “pelvic floor physical therapy” and similar names. The idea is that you talk with the patient first, to try to help (13,50-52), and first when you know that this does not solve the problem, you proceed to therapeutic touch (14-46).

We consider holistic sexology to be a subspecialty of clinical holistic medicine (52) that deals scientifically with problems arising from the patient’s repressed feelings. In principle sexual feelings are not different from other feelings, but they are often stronger and more difficult to integrate, since shame, disgust, repulsion, hopelessness, valueless and despair are normal feelings in this field. Ethics is extremely important in the field of sexology (53).

Sexuality is not the most important dimension of human life as we see it; love and consciousness are much more important for happiness than sexuality, and many people like monks and nuns live perfectly well without an active sexlife. But if you have a sex life and fail to find sexual happiness, this can be extremely frustrating or even painful. Physical pain from genitals during intercourse and chronically for no known medical reason continues to torment about 10 percent of young women in the Western world (28). Anorgasmia is very common, and most women in the Western world are not able to get orgasm during sexual intercourse. The explosive success of Viagra, in spite of this drug’s many adverse effects and other problems connected to its use, shows us that sexual insecurity and erectile impotency is a huge problem for a large fraction of males; most problematic are the problems this drug might create for the female partner (54).

Sexual health

Finally, many studies have found sexual health closely related to mental and physical health (13-15,35,47-51). All this makes sexology important. We need an integral science of sexology with good theories of sexuality and efficient therapy for the patients who need it.

We have researched the literature to find the classical methods, and we have combined them into efficient cures for sexual dysfunctions. We do not believe we are more efficient

than Reich or Masters and Johnson to cure these disorders, but we hope to do it in a more direct, simple and rational way and to inspire many more physicians and therapists to also work with sexological problems when they are presented in their clinic.

Working with sexuality is interesting and will often inspire personal development needed not to burn out in a busy daily practice with little variation, but more importantly, when chronic patients do not show any progress for an extended amount of time, working directly with sexuality can often get things going and the existential healing started (49).

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Section 1: Holistic sexology: Healing character and existence



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The Oedipus complex

This is about sexuality. It is about an arrested subject that technically is labeled “arrested psychosexual development.” What this does to the patient and also to the patient-physician relationship when this issue is addressed in the therapy, is the issue we are addressing. Sexuality is a difficult subject in our culture. In spite of porn in every small shop on the corner in most Western countries, dirty dating sites and millions of internet pages depicting all kinds of explicit sexual acts, which are viewed by a majority of young people, including females, sexuality remains taboo.

In the sphere of therapy and medicine, the taboo of sexuality is even stronger than in the rest of society. But sexuality cannot be removed, only repressed. It was the philosophical position of Freud, Jung, Reich and the other psychoanalysts of the last century that repression of sexuality was the most direct and important cause of mental disorders.

Today at least one in four in our civilized world is chronically, mentally ill, according to the national statistics (1). Could it be that we as physicians and therapists do not know how to integrate the repressed sexuality and make our patients heal existentially and become whole and coherent people? Could it be that the reason why so many patients are mentally ill is because of our difficult relationship with sexuality in our culture? This is the position of not only Freud and the psychoanalysts, but also of the whole tradition of holistic medicine and psychiatry.

In the patient-physician relationship sexuality often comes sneaking in, quite unexpectedly. In the beginning the mutual sexual interest or repulsion is not felt or noticed. But when the patients’ psychosocial development is becoming the center of attention, the sexual energy in the patient and between the patient and other people, including the physician, becomes enhanced. In this situation it is important to understand the nature of the sexual transference and countertransference described in detail by Freud, Searles and other great therapists; and it is important to know what to do with the sexual energies. They need to be accepted and integrated; repression of them will not help the patient to heal.

In this book we give all the information needed to deal competently with even the most difficult of situations: the strong female Oedipus complex caused by sexual abuse. One in seven girls in the Western world is sexually abused, so a large fraction of your mentally ill patient’s future life will depend on your careful understanding of the following chapters.

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Problems with sex and living together

Couple therapy is about helping a couple to function in the areas of love, mental interactions and sexual intercourse. To help other people live together is not an easy task. It takes a very good understanding of yourself, of man and woman and of culture. It takes a flair for personal development and the ability to intuit the specific meaning of a person's life (the life mission or purpose of life of this person). Sexuality cannot be understood separate from character and personality. Sex cannot be understood without understanding the person in depth.

There is an intimate connection between the general quality of the relationship and the level of sexual satisfaction for both partners. Often a sexual problem can be addressed in a soft and less direct way by focusing on the emotional and psychological aspects of the relationship instead of focusing directly on the dysfunctional sexuality. The younger the patient is, the more important is the care for the whole person and his or her feelings and emotions, integrity, attitudes and philosophy of life instead of a direct genital approach. With this said, the holistic approach will also often function very well with adult patients. The ethical principle of using the smallest tool that does the job has been discussed in section 4.

When the problems of sex and living together are understood as symptoms of underlying old existential wounds in need of healing and when the physician accepts the role as coach supporting the patient to confront these emotional pains, then the patient can heal existentially in order to obtain the wanted closeness and intimacy.

The change of perspective from: "He or she is not all right in..." to "I see that this is really about me, and what I have to learn is..." is where the patient assumes responsibility, and this is often efficient in helping the patient with problems in his/her sex- and love life. Intimacy is the most difficult art, where sexuality cannot exist without trust, vulnerability and surrender. This is often only possible after the patient has found his or her true self, including the purpose of life.

The physician who will give "holding" (care) and processing to the patient with the intention of healing the "wounded child inside," who cannot love and open up, can often help the patient to improve self-insight and change the whole quality and atmosphere of the relationship. The healing will end a series of symptoms of poor thriving, physically, emotionally, and mentally, and make life worth living. Sometimes a few successful holistic sessions are enough to change the whole picture and solve an emotional "knot" that has the potential to destroy the relationship.

Introduction

Loving each other and living together is a great art, which Kahlil Gibran described beautifully in his book *The Prophet* (1):

When love beckons you, follow him
Though his ways are hard and steep...

He threshes you to make you naked,
He sifts you to free you from your husks,
He grinds you to whiteness,
He kneads you until you are compliant ...

All these things shall love do unto you
That you may know the secrets of your heart
And in that knowledge
Become a fragment of Life's heart.

The incredible closeness we achieve with another person when we become lovers and partners will arouse the best and most sensitive, but also the most vulnerable, side of us—and almost always, at the same time, provokes our deepest sorrow, life pain and anxiety.

Closeness means that we are invited to devote ourselves—to be completely devoted and utterly honest—and in this closeness we have to be totally honest with ourselves and with the other person. We are often unaccustomed to this honesty, so that when love seriously comes into our lives, we are often forced to get to know ourselves better. We are obliged to be more honest with ourselves. This means that love often causes problems.

We discover that we find it difficult to be as close to ourselves and to the other person, as honest and open as we can be and would like to be. To be able to love, we need to heal as persons, in other words...we need to heal our soul. Existential healing is not well understood, but it is the central theme for consciousness-based medicine, so let us give a brief review of our work in this field before we suggest what the physician can do to help the great many patients who appear in the practice with a wide range of symptoms of poor thriving in the one-to-one relationship, from headache over depression to pain during intercourse.

Taking responsibility for your own life pain

Since early times, people have been described as being in possession of both a false and a genuine self. At first glance, this view is strange and peculiar because it means that very often we are not ourselves and not the person we claim to be. There is a depth in us, and at the bottom of this depth you will find the genuine self. On the surface, we have the more false side, the façade, which we show to other people. This way of thinking has given rise to a number of well-known sayings and expressions, the meaning of which most of us recognize from our own lives: “being in harmony with yourself,” “getting away from yourself,” “losing yourself,” “loving yourself,” “knowing yourself,” and so on. How could we love or not love

ourselves, if we did not have these two selves? The question that naturally arises for a thoughtful person is why we need two selves. What is the purpose of this?

One answer is so that we can become the one we are, as Marcus Aurelius (Rome 161–180, emperor and philosopher) put it, or in other words to say that we have a personal development project. If we were our true selves from the start, we would not need any development. The purpose of the pain is to draw our attention to the fact that something has gone wrong in our attempt to realize our true self. Another, perhaps deeper, answer to the question of the two selves is concerned with our early experience and with the life pain hidden away in us. Between the genuine selves, which deep down we are, and the more superficial façade we show to other people, there is a distance, an internal space, which is filled with old problems and painful life events that we were unable to overcome when we were small, and therefore have been swept under the carpet while we were growing up and to some extent repressed.

This causes us problems. One of the most serious is that the façade creates distance from other people and that our constant longing for love and closeness persistently enjoins us to drop the façade and be more honest, true and more natural toward one another. At the same moment that there is intense and genuine meeting soul to soul, the façade comes down, and those problems that have been hidden away below the façade reemerge on the surface of consciousness. That is why it is painful and problematic for us to come close to other people.

Fortunately there is a simple solution to this problem, as we can project the pain. When we have a repressed problem—a human fault, a life lie—in particular one we share with the other person, instead of taking responsibility for our historical pain, we can project it onto the other person.

Now the other person becomes really bad! “You see the mote in your brother’s eye, but you do not see the beam in your own eye,” Jesus said about this problem. The great art of life is to take responsibility for our own pain, our own faults and our own deficiencies and learn lessons from everything that happens, and in particular from everything that hurts us. We all have something to learn to become more complete people, to become more ourselves. We all have some black life lies that our quality of life could do well without.

Female, aged 25 years, used and discarded

Quality-of-life conversation: Would like to divorce her husband and return to Asia, where she originated from. Would also like to complete her education—there are two months to go. I (SV) advise her to stay for those two months and finish the relationship properly. Split what they have and return to her homeland in a calm and orderly manner, as a winner who has seen the world, and not as a young woman who has been poorly treated by her Danish husband. Further conversation in five weeks.

It was difficult to come to Denmark as a young woman, be used for sex and then discarded. We believe there is an important lesson for the woman that love and mutual respect are more important than material wealth and one should not sell one’s soul and body for economic prosperity.

Retaining dignity and going home with both money and education provides a good basis for the future. Fleeing and leaving everything behind is not good. Our conversation was concerned with preserving values, and we believe that the insight she gained improved her situation radically.

Female, aged 34 years, and divorce

Consultation 1: Comes to the clinic in desperation—everything is going off the rails—her husband wants a divorce, they have a 3-year-old child together and she herself has two children, a girl of 7 years and a boy of 9 years from a previous relationship. Is no longer able to remember things, cannot concentrate, cannot watch television, cannot find her way to places, is completely out of it. Has considered taking her life, but no specific plans, thinks about the children. What is to happen on Sunday, when she is to due to meet her husband for the first time in a long while to make arrangements for a divorce and so on? Her husband says she is always morose and negative and critical, which is correct. We talk about it probably being best to divorce if it is simply not working, but that it is important to find an arrangement that works for the joint child—and for the others. The first husband must also come onto the scene to help her with these children. She has girlfriends to talk to. On examination: assessed as not seriously depressive, no reduction in speed of speech, no waking in the early morning, slight loss of appetite, very little lowering of mood. Says that things have been going better for her during our conversation. Has to compile a list of all her problems. We talk about being true to oneself and about emptying one's "internal waste bin"—but first looking at and accepting everything that is in it. Can return next week, when a plan will be made.

Consultation 2: Appears to be in less desperation. The situation is much more clarified. They have agreed to divorce. The patient is considering a reasonable settlement in the divorce, as they have been married for 3 years and moved into the husband's house. Perhaps she will only take what she herself has contributed to the house, out of consideration for their future in relation to their joint child. Has thought about her internal waste bin and brings along a list that reads: Jealousy, hatred-love, loneliness, uncertainty, money. **EXERCISE 1:** Sit in the internal waste bin—be there and be aware of everything you feel. Define the time with an egg timer: 5 minutes in the first week, rising by 5 minutes every week, until 20 minutes daily. Write down everything that happened to you while you were sitting there when the time is up—particularly negative things you felt and thought about, such as old unfinished events in life. **WRITTEN EXERCISE 2:** Write about the new life you would like to have: the values it is to be founded on, how you would like to be, etc. By all means make some specific plans to move on. Next appointment in 5 to 6 weeks (due to holidays).

Life crises and divorces are among the worst, particularly when children are involved. However, it is not as impossible as it may seem when one is in the midst of it. The children can cope with it well if the adults can. The difficult aspect is that one has put up with so much, that one has made so many compromises, and suddenly one is no longer able to. The internal waste bin is full to the brim; NOW it has to be cleared out. A calm, neutral person who can supply intelligence and an overview from outside can be very valuable. The family physician can be such a person.

Female, aged 49 years, male aged 55 years, problems with relationship

Quality-of-life conversation with the couple. He has problems with his partner who sometimes is very hurtful. Together with his partner, he is trained to say: "Ouch!" "Now you're being nasty to me." "Now you're hurting me."

They both understand the situation well and accepted that they can practice when they are together. She would like to go for a drink with him, which he routinely refused because many previous episodes of running away and drinking on his part made this a bad idea.

Love hurts

Perhaps we do not understand why love hurts. Love is one of the greatest passions in life, but also something that is hard to understand and comprehend. It is when it is not clear to us that we have a mass of wounds in our souls, as everyone does when they have passed their first childhood. When life has hurt us too much, we have fled from the pain by lying to ourselves and distancing ourselves from life. Perhaps we have decided that we are not worthy of being loved, that we are not really lovely or valuable, that we are not beautiful and attractive. All these decisions and negative attitudes toward life are suddenly in the way of love.

Most of us have forgotten that life has hurt us and we are therefore surprised that closeness brings out pain in us, when we expect joy. But it is common to all of us that we hold within us old pains, which means that we are cautious about ourselves—often so much so that we do not allow anyone to come really close to us and touch our innermost being. We remain a little reserved toward each other. When problems unexpectedly arise, we are surprised and perhaps do not see that the pain comes from within ourselves.

From a reserved position, we look at the other person and often find a mass of faults, which worry us and perhaps make us unsure and afraid of the other person. Then we start to criticize the other person. We demand what we think we need and refuse to take what we would like to be free of. And soon afterward we start controlling each other with all kinds of boring power games, which destroys for good the joy of being together.

Love life is the door to the divine

Sexuality will flourish when we let go, dare to be ourselves, natural, open and living. Our sexuality can express itself freely and exuberantly when we are relaxed, confident and natural together. We all have great gifts with regard to sex, even if we have more or less suppressed our sexuality.

Sexual problems are very common. We found in the Danish Quality of Life Survey (2) that one in four people have serious problems in functioning sexually and probably just as many have minor problems. The problems may be due to purely biological factors, but are far more often a symptom that something in us and in our relationship as a couple is not entirely the way it should be. The problems are often imbalances, which can easily be corrected by better understanding.

Female, aged 20 years, and nymphomania

We talk about sexuality: The patient has always experienced clitoral orgasms, never vaginal orgasms. We talk about her sexuality being masculine and outward, instead of feminine and inward. Her boyfriend is correspondingly feminine and sensitive. It is a great problem that she always desires sex, because this means that her boyfriend feels dominated to the point of not having desire. This pattern is natural, when the patient is never deeply satisfied sexually due to her masculine pattern. Her abdomen feels cold over her womb and I (SV) tell her that I am melting ice cubes in her stomach, which is a childish but symbolically true way of expressing it.

It is possible to make considerable progress by practicing being natural together and practicing enjoying each other in and out of bed without demands, control and criticism. But if it is not appreciated that the underlying factors interfere, until they have been understood and processed, the sex life will never be optimal.

Our love life has enormous potential; it can become our opening to the divine. Our sexuality may be the door to the greatest and most delightful experiences in our lives. But all too often, people do not feel the great enjoyment in sex. It becomes a small, cold and slightly laborious affair. Perhaps even a duty that has to be fulfilled quickly. And it need not be that. About one in two couples who marry and promise each other eternal fidelity end up in divorce. The first thing to go wrong is often the sex life. From a modern point of view, there is nothing wrong with growing apart. The problem is merely that the difficulties often persist with a new partner.

When we start working consciously and deliberately on love and sex, we are often presented with some fundamental and uniquely beautiful and joyous tools, which can take us further in our personal development as people. As the patient develops self-respect, self-care and focus on his or her own development and well-being, he or she steadily becomes better and more valuable to the partner as well and to children, friends, work colleagues and everyone else who is encountered.

Female, aged 28 years, power-wielder who cannot function with boyfriend

First quality-of-life conversation: The patient suffers from lack of a boyfriend and a chronic feeling of being rejected. I would say that the feeling is: "He does not like me." Has been married, has two children, boy aged 8 and girl aged 5 years. The boyfriend for the second time has found someone else. She is "emotional," as though made for love, care and sex, but she is blocked in this and is now unable to love. Her father regarded her as stupid and delightful. Her mother, whom the patient calls manipulative, found her irritating. The patient acted as a psychological mother for her own mother, and as a partner for her father. On examination: Many tensions in the back and particularly in the abdomen, around the pelvis and the insides of the thighs. Cries when these tensions are contacted. There is a "pit in her abdomen." Patient is not at home in the hara center.

EXERCISE 1: Let go of negative decisions: "I'm no good" and "I'm irritating."

EXERCISE 2: Patient is overweight, 10–20 kg, and eats in the evening in order not to feel. Therefore, sit for 10 minutes daily in your emotional space and feel your emotion of being let down and rejected, insulted, fed up and so on.

EXERCISE 3: Find more negative decisions in their precise formulation and let go of them.

PLAN: Rosen sessions every 14 days, appointment with me (SV) in between if needed.

Second quality-of-life conversation: Was annoyed when I arrived late for the appointment. Put it off until the next day, as she was "full" from the Rosen session today. Her mother was always irritated by her. Since the patient was 3 years old, she has always been contrary, defiant and stubborn. Did not want to show me her notes today. "I'm no good" is the basic problem, the patient says, and: "I'm not worth loving." She appears to be a typical power-wielder.

EXERCISE 1. Describe all your advantages in wielding power.

EXERCISE 2. Make lists of all your power games in relation to love, sex and friendship, as well as work and motherhood.

Third quality-of-life conversation: The patient hands over a list of power games in relation to children and husband. It is clear that the patient wanted to be in charge and to

control both her son and her ex-husband, when they were together. During the conversation, the understanding is crystallized in the sentence “I determine...” in the sense of....everything! Since she was 3 or 4, the patient has been “a sweet, warmhearted, and fair tyrant” in relation to those around her.

EXERCISE 1: Let go of the sentence “I am in charge.”

EXERCISE 2: Accommodate your anger and other emotions, and be a pressure cooker for next time. She is to go for a Rosen session tomorrow, which is entirely right as she can feel her emotions there, supported by the loving hands of the Rosen practitioner.

This kind of “I am in charge” decision, which guides the patient in her subconsciousness, is a very serious and destructive decision that has been made at a time of extreme distress during childhood. When the patient finds it and lets go of it, the whole of her energy, the whole quality of her personality will change radically. It is incomprehensible and quite alarming that our old decisions have such power over us, that they destroy our life all together throughout our lives. We create our life through our decisions. It is therefore vitally important to be clear about what decisions are at work here and now.

Sixth quality-of-life conversation: The feeling of being rejected has disappeared. The feeling of being irritating has disappeared. Power games have disappeared, and the patient spends time with her children in a far more caring and loving way. Very few conflicts with the children. “Yesterday they sprayed water all over the bathroom, and I didn’t even lose my temper. Previously I was not allowed to console my son or come close to him; now I can do that.” Finished.

Discussion

This problem afflicts one in two modern people: we cannot make our life together work. The younger the patient, the more likely this will be a problem. Attempts are often made to solve problems in relationships by power. That is not nice. Resignation or breakups and divorces are normally the result: submit or disappear! But before love finally dies out, the energy left in the love is often channelled into long and painful power struggles. The power games are generally based on earlier patterns of survival from childhood. When patients let go of their decisions about having to be in control and determine everything, they can then enter into a warm and rewarding relationship of love. Power games are highly destructive for love; fortunately most patients are willing to let go of the dark power games when their attention is drawn to them.

When the problems of sex and living together are understood as symptoms of old existential wounds that need to heal, and when the physician accepts the role as coach supporting the patient to confront the underlying emotional pains, the patient can heal existentially and obtain the wanted closeness and intimacy. The bare change of perspective from: “He or she is not all right in...” to “I see that this is really about me, and what I have to learn is...” where the patient assumes responsibility, is often efficient in helping the patient with problems in his/her sex and love life. Intimacy is the most difficult art, and a free and sound sexuality cannot exist without trust, vulnerability and surrender, often only possible after the patient has found his or her true self, including the purpose of life.

The physician who gives holding and processing to the patient in the intention of healing the wounded child inside, which cannot love and open up, can often help the patient to—in a process of a few months or years of duration—improve self-insight and change the whole quality and atmosphere of the relationship, and often a series of symptoms of poor thriving (physically, emotionally and mentally) will disappear in this process. Sometimes a few successful holistic sessions are enough to change the whole picture and solve an emotional “knot” that has the potential to destroy the relationship.

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Psychodynamic therapy - and beyond

In the following pages we follow the classical route of psychodynamic therapy inducing accelerated psychosexual development of the mentally ill patient (1). The sexual nature of the disturbance causing the mental symptoms is becoming clearer and we are now able to understand and treat personality disorder, illnesses of the schizophrenic spectrum and eating disorders.

Body, mind, spirit and heart are all bound together by an internal flow of sexual energy; if this energy is disturbed severe mental symptoms are seen. The problem of this model is that it is rather philosophical and not easy to test empirically; the results of the treatment on the other hand are easy to measure.

So the qualitative dimension, the subjective experience of the disturbed existence, are becoming more and more important the deeper we go in the mental disorders. To treat schizophrenia the holistic physician needs a thorough self-insight that allows for the recognition and understanding of the abnormal psychic structures in the patient. A strong intuition will guide the healer to help the patient identify and confront the original traumas that created the mental splitting or other pathological pattern of mind and spirit.

If you have read the previous sections, and if you have been treating your first patient like we recommended you do in section one, you will most likely instinctively know what we are writing about here. If not you will need to find your first patient to treat with holistic medicine now. You will not be able to learn to heal without practical experience and reflection on your own failure to help and cure. Holistic medicine is not a theoretical thing but a highly practical thing. You need to practice. Please start today. We recommend that you re-read our advice regarding this in the introduction to section one.

Your first patient should not be very difficult. Your first patient should help you understand the principles of holistic medicine and make you feel confident and successful. But if you have a heart for a very ill and dependent patient, you can as well start here. Just know that the more ill he or she is the more he or she will depend on you for being cured, and the less you will be able to withdraw from the treatment before it is done, which can take several years.

It is a responsibility. Do not take it too easy. You will be responsible for this fragile life. It is very similar to getting a baby. You will be responsible until the baby is grown up and ready to life on its own. Do not engage in treating anybody before you are ready to carry this

responsibility on your shoulder. But then again, you should also realize that nobody is likely to help the person if you are not helping. Therefore, even if you fail, the patient is not likely to be worse of that he or she is today. So forgive yourself if you cannot carry the burden. Do try. You will grow with the challenge.

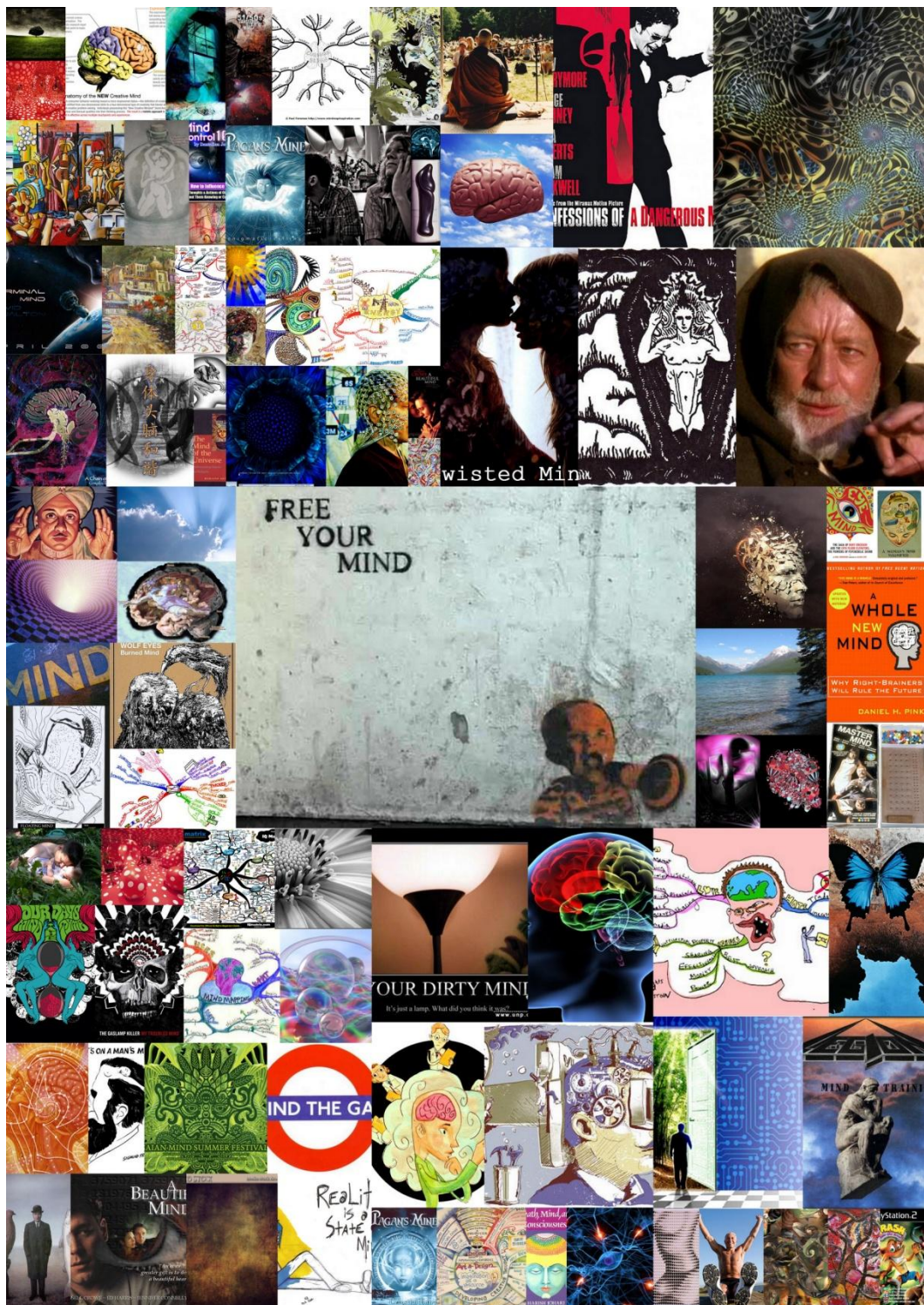
If you love the patient; if you truly do, do not hesitate to offer your service. You might find out that while you believe that it is you that set your patient free, it is actually the other way round: the patient sets you free. For the biggest gift in this world is not to give, but to receive and allow other people to give their gift to you. The Native Americans always upheld receiving as the highest spiritual discipline. Giving is in that sense for beginners. When you mature, you will be able to truly and egolessly receive the gift of the other.

When you work on healing your patient you will notice that every time a patient is healed you have received a huge gift. Only if you can allow yourself to receive the gift of the patient, your patient can heal. The love that you started has become mutual. Now the patient loves you. Therefore the patient can love again. And being able to love is what life is truly about.

When you finally end the treatment and separate, this love the patient has felt for you is available for another person. By letting go of him or her you have helped your patient to relate intimately to another human being. A new life has started for this person. If love, consciousness, and sexuality have been sufficiently developed the patient will also be cured at this point in time.

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Sexuality and existential problems

From an abstract view all existential problems are identical. But the more concrete you look at it the more different the situations become. Some patients that appear to be mentally ill are just caught in social predicaments they cannot solve; simple coaching that help the patients solve their marital problems, problems with friends or colleagues is often enough to alleviate a situation that for a first glance looked like several years of hard existential therapy.

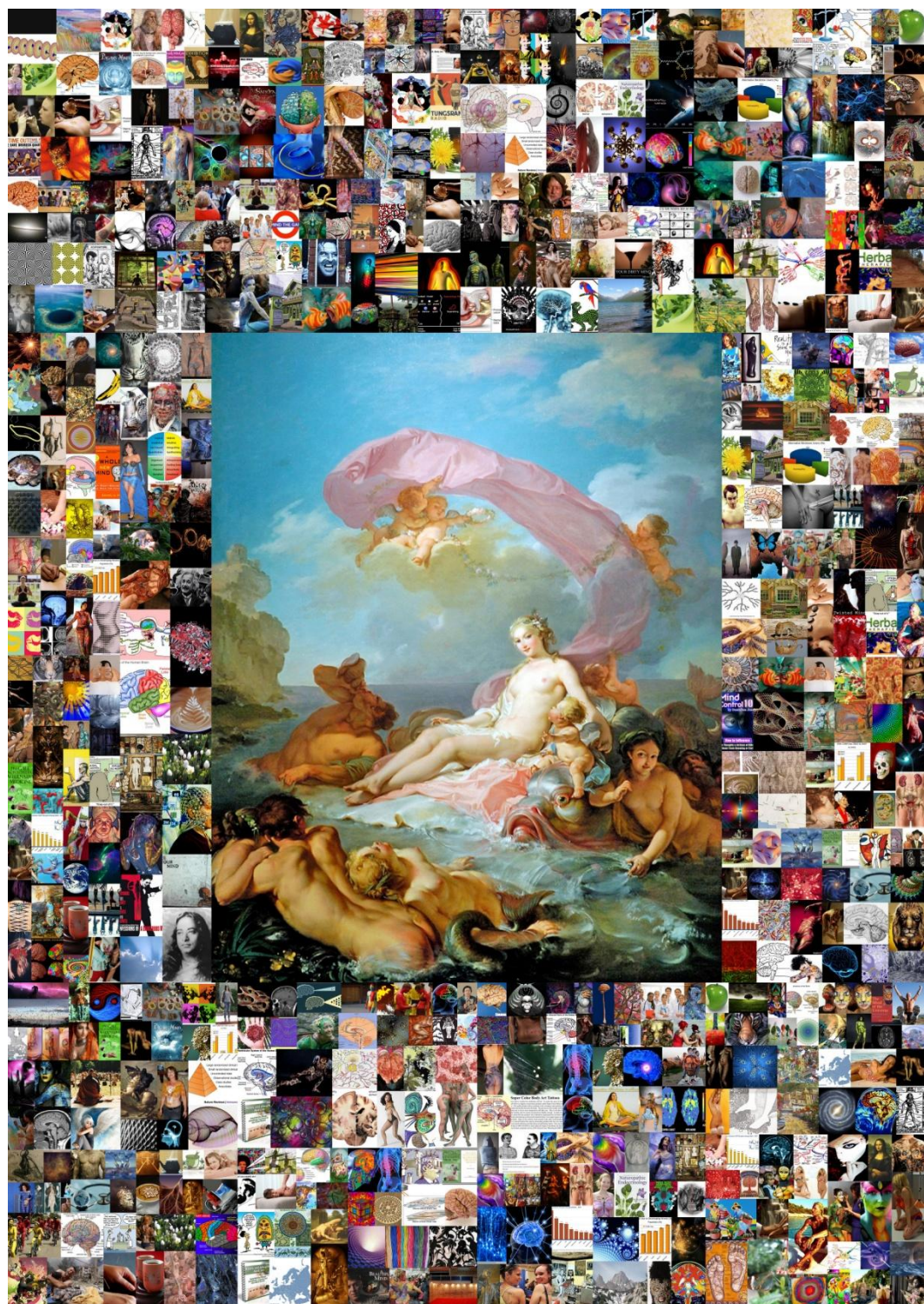
Very much the same clinical pictures can be caused by severe sexual traumas of incest or rape. In this situation holistic sexology and holistic psychiatry merge together into a coherent holistic medicine addressing the patients' description of purpose of life (life mission) and similar fundamental structures in the patients philosophy of life.

Existential crisis are yet another cause of the same clinical picture. This is completely different as the patient simply often has continues a course in life that did not renew and inspire. After sufficiently many years the persons' emotional life is almost dead. Holistic rehabilitation is urgently needed.

Finally dependency is another pattern that can materialize as severe mental disorder. Dependency is basically to urge to substitute what one have inside one self, but which one does not believe to have, with something from the outside world. It is basically a misconception, caused by early emotional problems that can be solved by confrontation and self-insight. It is not really important to be able to classify or diagnose the patterns behind the mental symptoms but if they are seen it makes the treatment faster and easier. The theoretical structure of these different patterns of personal decay is not well-defined. Actually, the deeper one goes, the more they appear to be the same. And if one goes all the way, it becomes obvious that what create all the problems is just illusions – what in Buddhism is called “Maya”. The cause of all suffering is not knowing, not acknowledging and not appreciating one's own divine nature (1).

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Sex and Viagra – An introduction to the paradigms of sexology

Males tend to go for genital potency, while women tend to go for deeper emotional and spiritual experiences in sexuality. Men often live in practical, simplistic, mechanical paradigms, while women live in complex, social, emotional, and spiritual paradigms. Male sexual dysfunction indicates fundamental problems in the couple's sexual interaction; the solution to male sexual erectile dysfunction is therefore not a drug increasing genital hardness, but rather sexological couple therapy, developing the couple's sexual consciousness and the understanding of the genders different characters. The conflict between mechanical and holistic worldviews is classical in sexology. Kegel found that sexual dysfunctions including dyspareunia, lack of desire and orgasm was caused by weakness in the pubococcygeus muscle, while Reich believed that low orgasmic potency was caused by a blockage in the life-energies that should flow through the whole body and be fully integrated in the human character. Freud believed sexual dysfunctions to be caused by the repression of sexuality into the unconscious. Jung believed that orgasmic potency came from our ability to accept and meet out inner anima/animus – the opposite gender in our sexual shadow. In the tradition of erotic tantra the sexual energies are cultivated and circulated through body, mind, spirit, and heart. The optimal sexological treatment is multi-paradigmatic and allows the couple to analyze their sexual paradigms to come to an understanding of self and the partners physical, emotional, and spiritual needs in sexuality. Viagra® does not always solve the psychosexual problems related to erectile dysfunction and is likely to increase female dyspareunia.

Introduction

Sexuality was an object for intensive research in the first half of the 20th century, with great discoveries that lead to establishment of the medical science of sexology around 1960. Since then thousands of sexologist, some of them physicians and other therapists, have helped millions of patients with sexual dysfunctions. Recently the pharmaceutical industry has contributed to sexology with the development of sildenafil citrate (Viagra ®) for male

erective dysfunction. In spite of the understandable popularity of this drug among impotent men, the effect on their female partner has not really been discussed. Tiefer (1) has reflected on the fact that the pharmaceutical industry has systematically withheld the data from the partner-survey from publication. This is likely to indicate lack of a positive effect on the female partner's sexual satisfaction, or even worse that the female partner is experiencing more problems and sexual pain because of the drug.

In our sexological clinical practice we often heard female partners express their disappointment with Viagra®, as it has not improved her sex-life. The real need of a female, she will say, is not "hard sex" but a relationship that is playful, experimental, deeply emotionally involving, and even spiritually enlightening. These concepts are often fundamentally lacking in the male universe, making the women feel his male energy somewhat hard, mechanical, simplistic and alien – sometimes even described as an emotionally and spiritually wasteland. Insensitive penetration causes often pain, which is the most common female complain in the sexological clinic, and it is insensitive penetration that makes her reject him sexually giving him problems with his sexual self-confidence and these emotional problems are the true cause of his erectile dysfunction. The couple's sexual problems are thus going deeper than just being an evil circle that can be broken with Viagra®.

To rehabilitate female orgasmic potency, with all its elements of desire, excitement, enjoyment and lack of pain – it is often necessary not only to work mechanically on strengthening her pelvic floor musculature, but also to help her develop self-confidence, acceptance and even to heal emotional wound from her youth- and childhood sexual traumas. It often takes a great existential awakening to help a woman back to full orgasmic potency (2,3).

Male sexual problems are normally connected with lack of erectile potency and premature ejaculation; both these are well known from sexological research (2) to be strongly connected with psychological factors. It is worth remembering the fact that Masters and Johnson were able to cure almost all impotent men in just 14 days using a competent female substitute partner, documenting the psychological dimensions in erectile dysfunction. Confidence, self-insight, acceptance of own body and sexuality, and a deep understanding of the differences in men's and women's sexuality seems to be what is needed to be a sexually able man. This is also what a woman needs to open up emotionally and spiritually for the man, not just a hard member, as many men seemingly still believe.

Sexological paradigms

The word *paradigm* refers to Kuhn's famous work on scientific paradigms (4). In sexology the sexological inadequacies have been understood in very different ways.

The mechanical paradigm

Kegel (4,5) saw most sexual problems coming from the simple mechanical weakness of the pelvic floor muscles, primarily the pubococcygeus muscle around the vagina. In 1948 Kegel found that the ability to tighten the vagina around the male penis, an ability that he

documented varies much from women to woman, is essential for good sexual functioning; he therefore developed the famous “Kegel exercises” to strengthen the pelvic floor musculature (4). In the second paper in 1952 Kegel wrote (6): “Summary. Findings in the present series indicate that sphincteric and sensory sexual function of the vagina is practically always potentially present, and can be developed through muscle education and resistance exercise. Every woman with sexual complaints should be investigated for possible dysfunction of the pubococcygeus muscle. In a large percentage of cases it will be found that “lack for vaginal feeling” and so-called frigidity can be traced to faulty development of function of the pubococcygeus muscle (6). Graber and Kline-Graber continued this research (7).

Hartman and Fithian wrote in 1972 (8): “It is important to determine whether there is any sensation or awareness in the vagina. Some women are unaware if the examining finger or if the speculum is in or out. What we attempt to do is to get her to focus on the feeling in the vagina, with an examining finger in the vagina. We found that often nothing has ever been in the vagina long enough for her to have developed any perception, and because of this, she may describe any movement as pain. This is easily determined if the pain is inconsistent in location.” (8, page 81). “About one out of ten women that we see are not able to move their vaginal muscles at all. In these women the vagina is often gapping and open, and they usually have some problem with stress-incontinence. In such cases we have difficulty in getting them to move the muscle enough to identify it so that they can learn to do the vaginal exercises. However, if they can learn to do the exercises and will do them, remarkable changes can take place in the physiology of the vaginal barrel, even where here has been extensive trauma in childbirth” (8, page 82). “The woman has the organ of accommodation and can develop a tight vaginal vault where she can receive much more friction and feeling trough vaginal exercises. This is not only positive for her in the vagina, but also a tight vagina will cause more movement of the foreskin over the clitoral shaft which will increase her satisfaction and pleasure. We feel that it is to the advantage of both the female and male...” (8, page 89-90). “If there is a tear or lesion in the wall of the vagina and we insert a finger in that area or we flick the band where there is any fibrosity, this can often be painful and the woman frequently responds by saying, “What is that? That is exactly what happens in intercourse, but I have never been able to find out what it is.” We can assure the woman that it is simply a fibrous band or a separation on the vaginal wall and can easily be filled in or corrected by her doing the suggested vaginal exercises (Kegel pelvic contractions)” (8, page 86).

“A well-conditioned vagina is long and narrow. It should be remembered that a vagina is not an actual space, but a potential. It is by inserting a finger and moving is against the wall we ascertain the contour, since the fleshy part of the vagina meets the resistance of the vaginal muscles when palpated with a finger. If you notice again our illustration, you will see that the bottom left-hand boxes, which are divided into thirds, identify the vaginal barrel right and left by lower, middle and upper third, which have different markings on them. The top third of that indicate no observable muscle. It is in poor condition with a lot of fibrosity indicated by the x. The lower third has a circle with an X, which indicates there is some muscle response there, but here is fibrosity or sessions in the muscle. The lower part indicates the muscle is in better shape having less fibrosity in the right side still not too good. If you look at the last set of boxes, you see that in a year’s time the mobility has markedly changed“ (8, page 92).

The mechanical logic is clear, and the text leaves no doubt that a woman, who is able to catch her partners member in a strong, dynamic grip will have her vagina and clitoris well

stimulated this way, offering also the man the physical stimulation needed, thus bringing them both to full orgasm. You could say that this is the first, basic level of genital sexuality: When there is a functioning intercourse the rest is just details so as a sexologist you would be wise to focus here. And if you believe that a harder member can compensate for a weaker vagina, Viagra® is a good solution to the problem of male erectile dysfunction. Clearly a man with an artificial erection can have intercourse, but this is not automatically giving the woman sexual pleasure; only the most chauvinistic of men believe today that a hard member is enough to satisfy a woman. The emotional contact is the most important thing for a woman and as the couple's emotional problems are also in most cases the true cause of the erectile dysfunction; therefore the emotional problems must be solved to increase sexual satisfaction for both the male and the female.

Holistic paradigms

The word “holistic” means “with regard to the wholeness”. The first part of the 20th century gave birth to several holistic sexological paradigms.

Sigmund Freud (1856-1939). The most influential has without doubt been the understanding of human sexual development by Sigmund Freud, from the oral to the anal and finally the genital sexuality (9). In spite of the simplicity of this idea it has led to highly complex intervention restoring the patients sexual ability through regression all the way into early infancy, to rehabilitate sexuality at its very roots. Freud's early idea was that sexuality was repressed through childhood traumas, but later he believed that it was human nature to repress sexuality as we, the Ego, were destined to inner conflicts between our animalistic side, the Id, and our social consciousness, the Super-Ego. The conflict theory put sexual transference and counter-transference in the centre of psychodynamic psychotherapy.

Wilhelm Reich (1897-1957). The person who in reality created the science of sexology was Wilhelm Reich. Reich succeeded in mapping the sexual cycle in the curve of orgasm, which is the basis of all sexological understanding today. He understood the orgasm as the release of sexual energy, which had built up between the genitals and the rest of the body. The higher developed sexually a person was, the more sexual energy could be charged on this inner battery. Therefore the whole body was involved in sexuality, not only the genitals. The whole character of the person should integrate the genitals and the sexual energy and become what Reich called a *genital character* (3,10). Reich found that sexual bodywork combined with psychodynamic psychotherapy helped the patient to heal not only sexual dysfunctions, but also somatic and mental health, including in some cases schizophrenia and cancer. In the last half of the 20th century researchers like Searles (11) and Levenson (12) took these ideas to the next level and developed cures for schizophrenia and cancer that are still under scientific investigation with regard to their efficacy.

Carl Gustav Jung (1875-1961) was strongly inspired by the Eastern concept of sexuality, where sexual energy is seen to circulate through the whole human being and thus energizing and integrating body, mind and spirit into the abstract human “heart” (13). Jung saw sexual tension as a building up between the person's own gender, which is expressed outwardly, and an inner core of opposite sexuality, which Jung called the anima/animus. The Eastern idea that we are total, all-inclusive beings found its expression in human sexuality. According to this model all sex is masturbatory; when we engage in sexuality we only project our inner

male or female part into our partner. The more sexually healthy we are, the more can we accept our anima/animus, and the more sexual energy can we accumulate in our system, and the stronger can we project sexual attractiveness into our sexual partner. The whole tradition of erotic tantra is close to this understanding (14).

Sexological treatments according to paradigms

The treatment of sexual dysfunction is strongly depending on how the patient and the sexologist understand sexuality. In a mechanical paradigm the goal will basically be to get the intercourse going. The man can be helped with Viagra, and the women with pelvic floor exercises (“Kegel’s”).

The sexological examination

A more integrative approach has been the sexological examination developed by several clinicians (8,15-20). The sexological examination is actually a series of interventions that are both explorative and therapeutic-educational at the same time (a medical concept often called “clinical medicine”); the four steps are described by Hoch in 1986 (16, p. 768):

Gynaecological examination: The gyneco-sexologist first proceeds with the gynaecological examination. Inspection and palpation of the external genitalia may reveal involuntary contractions of the pubococcygeal muscle, in which case it is advisable to ask the patient to contract and relax the anal sphincter, thus teaching her how to control the perivaginal musculature. In order to familiarize the patient with her own body, she is instructed to introduce first her own fingers and then the examiners fingers into the vagina.

Vaginal acupressure: The examiners fingers are moved to and fro, starting on the posterior vaginal wall and then slowly proceeding toward the lateral and anterior aspects of the vaginal canal. Touching and light pressure are alternatively used on every part. Proper lubrication of the fingers is necessary during this part of the examination. The patient is asked to concentrate and to indicate her sensory feelings during stimulation of the different vaginal regions. Her reactions are recorded.

Vaginal sexological examination: If she indicates discomfort, pain, or no special sensation, the fingers are slowly moved on, until an erotically reactive area is identified. Stimulation is then continued on the area for a while, but never longer that required for reaching the excitement phase of beginning plateau phase of her sexual cycle. When stimulating the anterior vaginal wall, pressure applied to the second hand on the suprapubic region proved to be very helpful in enhancing the patient’s sensation. This bimanual stimulation is performed in a steady circular fashion, almost bringing the two examining hands together. The external hand of the examiner is then replaced by the patients hand, teaching her how to locate, through her abdominal wall, the intravaginal examining fingers.

Partner exercise: The last step is giving the couple sexological exercises for home practice.

There are today several types of sexological examinations, the “Hoch” type is very medical and oriented towards pathology and dysfunctions, although it clearly includes the

emotional aspect of sexology, while the “Pomeroy-Brown” type is much more holistic. Pomeroy and Brown rebelled against Hoch (15) in 1982: “This difference between a sexological exam, as advocated by Hoch and our own system emphasizes the fundamental difference between a medical (i.e. a pathological) approach and a pleasure approach to sexuality. The former focuses on illness, deviance, and pathology and is the most common approach used in Europe and elsewhere outside the US. Fortunately, in the US we have finally realized that the medical model is inappropriate and are now concerned with health, pleasure, communication, sensitivity, and awareness which allows for change and growth far beyond that conceptually possible, employing the medicinal model” (17, page 73). “For a non-medically oriented type of sexological examination, since the focus is on gathering and imparting information on anatomy, physiology, arousal patterns, response cycles, and pleasure zones, any knowledgeable and sensitive sex therapist should be able to conduct the procedure skilfully. Medical training is not necessary for this nor is it necessary in order to know how to insert a speculum. This skill can be gained rapidly – evidence by the many women’s self-help groups that have sprung up throughout the country. The women in these groups learn to insert specula both in themselves and other women and learn to examine the cervixes, vaginal walls, etc. Furthermore, Hoch’s manner of examining the female appears to be too medically focused and lacking in relaxation, since the woman is on an examining table with her feet in stirrups, as in a regular gynecological exam. In our sexological exams, we try to have the woman reclining on large, overstuffed pillows in order to eliminate the elements of fear and tension that are often present in a medical atmosphere” (17, page 74).

Hoch is also insisting on not involving the patients whole body, while Pomeroy and Brown insist that: “A sexological examination that does not include at least total body mapping, i.e. rating on a scale of -3 to +3 where and how a person enjoys being touched, is not a true indicator of a person’s sexual responses” (17, page 75). This must be understood as a clear indication of Pomeroy and Brown “going holistic”.

Vaginal acupressure/Vaginal massage/Hippocratic pelvic massage

The vaginal acupressure part of the sexological examination have always been an integral part of bodywork, physical therapy and physiotherapy and was practiced by the European doctors all the way back to Hippocrates and his students, where it is described in the *Corpus Hippocraticum* (21). Many medieval sources describe interventions almost identical to the sexological examination, including the provocative element of direct sexual stimulation (22-28). Vaginal acupressure/pelvic massage have in a number of studies been found highly efficient for sexual dysfunctions including pelvic pain (29-37). In spite of the common use of this kind of therapy, it must be realized that “there are no standard treatment protocols guiding the manual therapy” (37, page 518). There seems to be a general agreement among researchers that every therapist must find his own way here and include the elements that he or she finds most usable.

The technique of pelvic and genital bodywork has therefore also been described and practiced in many different ways. We saw Hoch’s description of vaginal massage in step two above; a more contemporary description of pelvic physical therapy was given by Rosenbaum in 2005, who concluded that: “Physicians recognizing and treating women presenting with vaginismus and dyspareunia should consider physiotherapists as vital members of the

interdisciplinary team” (39, page 337). “The physiotherapist’s assessment of the vulva differs from the gynaecological examination. Both the external and internal exam focus on the mobility and integrity of the muscular, fascial and connective tissue components. The vulvar and pelvic floor exam consists of the following: a) Observation of the vulva, perineum, and anus to note areas of redness, raised areas, scar tissue or oedema; b) palpation to note tenderness to touch; c) internal exam to assess pelvic floor muscle tension and tightness to touch; c) internal exam to assess pelvic floor muscle tension and tightness, tone, range of motion, and hymeneal presence and thickness; d) assessment of internal muscle trigger points; e) determination of the integrity of the pelvis organs and possible presence of prolapse of the bladder, uterus, or rectocele and f) anorectal internal exam” (39, page 335). “Conclusion: Physical therapy treatment of pelvic pain is an integral component of the multidisciplinary approach to CCP (chronic pelvic pain) and associated sexual dysfunctions. (38, page 513). “Manual techniques including massage, stretching, and soft tissue and bony mobilizations, are important components of treatment...” (38, page 517). “In assessing the pelvic floor muscle tone, important markets include muscle length, muscle tension, muscle stiffness, presence of trigger point, and pelvic floor synergy or presence of dysenergia” (38, page 517).

Weiss described in 2001 pelvic physiotherapy this way: “In contrast to external muscle group that physiotherapists treat manually with 1 or 2 hands, internal muscle groups limit the practitioners to 1-finger treatment via the rectum or vagina. Tenderness, tightness or taut bands are located. They are then treated with compression, stretching, strumming at right angles to the affected muscle bundles or allowing the finger to glide between fibres to seek toe direction of least resistances, termed following the well” (33, page 2227). “Any tender points are then eradicated by compression and stretching” (33, page 2228). “Treatment should continue until tenderness and tightness have dissipated, which requires 1 to 2 visits weekly for 8 to 12 weeks depending on the duration and severity of symptoms. (33, page 2228).

Bergeron et al (31) treated 35 women with vulvar vestibulitis: “Physical therapy yielded a complete or great improvement for 51.4% of the participants, a moderate improvement for 20.0% of participants, and little to no improvement for the other 28.6%. Treatment resulted in a significant decrease in pain experienced both during intercourse and gynaecological examinations; it also resulted in a significant increase in intercourse frequency and levels of sexual desire and arousal. ... Finds demonstrate that physical therapy is a promising treatment modality for dyspareunia associated with vulvar vestibulitis”(31, page 183-184). They concluded: “Physical therapy is one of the few treatment for vulvar vestibulitis that is non-invasive and has no known negative side effects. (31, page 184-185). They described their method as “physical therapy sessions”: “Manual techniques used for proprioception, normalization of muscle tone, pain modification, and mobilization were applied on the surface of the perineum and internally by vaginal and sometimes anal palpation. These techniques included, among others, myofascial release, trigger-point pressure, and massage” (31, page 185).

Vaginal acupressure is different from the sexological examination. Hoch wrote (15): “Stimulation then proceeds [in the sexological examination] to the external genitalia involving the vestibule, urethral region, labia minora, and clitoris. There are no standard techniques for successful clitoral stimulation. Different patients react differently to various sites, pressures, pace, and form of clitoral stimulation, but it will generally be successful if one common condition is met: The moment we have located what is best for our patient,

stimulation should be continuous and uninterrupted until a beginning plateau level is reached. Here again it is the patient's responsibility to provide the examiner with exact instructions for the achievement of successful stimulation" (15, page 61).

To us vaginal acupressure is a most simple procedure that is already an integral part of the standard pelvic examination: "It is important to understand that the procedure of acupressure through the vagina, is the same exploration part of the standard pelvic examination by a gynaecologist, but in this case done so slowly that the woman can feel the emotions held by the different tissues contacted by the finger of the physician. It can be used in combination with the pelvic examination and as the woman always will contact some feelings while examined in her vagina, the situation is really that every pelvic examination contains an element of acupressure through the vagina. Often the awakening of unpleasant feelings is very emotionally painful for the woman and if not taken care of by the physician/gynaecologist it will make the standard pelvic examination difficult for the woman, as many women actually experience. Just ignoring the fact that the woman is a living human being reacting emotionally to the pelvic examination is not going to help the woman not to feel"(40).

All the researchers seems to agree that there are no side effects of the manual sexological treatments, but there is some warning that most of patients with pelvic and genital pain has psychiatric co-morbidity (41). This does not at all mean that one should not help sexually dysfunctional mentally ill patients, but that the therapist needs to work with special attention to the patient's emotional problems as well as their mental, spiritual, and existential problems.

Even in the most mechanical and physical therapy, only rational approach when it comes to the sexological patient is holistic. Just taking care of the body is not an option. Most interestingly it has so often been found that therapeutic work in the pelvic and sexological area can cure not only pain and sexual dysfunction, but also cure the patient's seemingly unrelated mental and somatic illness (42). This strongly indicates that unsolved psychosexual developmental problems are causing severe and chronic somatic and psychological imbalance, distress, illness and disease.

Ethical considerations

Hoch (15) wrote: "The sexological examination of the female patient, as performed in our Center, has proved to be an essential and almost indispensable diagnostic and therapeutic tool for the treatment of female sexual dysfunction" (15, page 58). Hoch did not, in the light of the patient's obvious need of cure find any ethical problems in the procedure, but admitted that there was a problems in taking a female patient all the way to orgasm during the sexological examination: "Special care is taken to avoid high preorgasmic levels of sexual response, or orgasmic release, which might often evoke in the partner unnecessary fears of having "to compete" with the more knowledgeable (and often male) physician (15, page 62).

Alzate and Londoño (43) described the ethical problems in a research project with sexological examination, where the patients were taken all the way to orgasm: "Some comments on the ethical implications of this research are in order here, since in absence of any practical alternative the subjects reached climax with the help of the male examiner. Although there seems to be a consensus among sexologists on the rules that should govern

sex therapist/patient (client) interactions, and on the limitations of the sexological examination conducted in a therapeutic setting (but not on the professionals qualified to perform it), apart from the minimal requirements of professionalism, confidentiality, and consent, the ethics of sex research should be flexible enough not to hinder the advancement of knowledge, once the human subject's protection has reasonably been taken into account. Therefore, we believe that our examination procedure, which might be improper in a therapeutic setting, is ethically acceptable as long as the examiner keeps from being erotically involved with the subject, which was the case in this study (43).

The researchers seem all to agree about the Hippocratic ethical rule of not having sex with the patients, but it is highly doubtful that sexological work can be done without some sexual excitement of the therapist as both Freud and Searles have admitted (44,45). Yalom (46) also argued that this is absolutely normal and should not be considered a problem: "I have been sexually aroused by patients and so have every therapist I know". The therapist's sexual arousal, which is often higher in the beginning of his sexological career when everything is still new, is not a problem if the therapist knows how to control his behaviour. In our experience the experienced sexologist easily controls the level of sexual arousal, sexual mentation and sexual behaviour.

As manual sexological therapy has no side effects all researchers seem to agree that there are not ethical problems with manual sexological treatment, e.g. the sexological examination, if only the therapist respects the Hippocratic ethics. Recently the Hippocratic ethical rules have been re-formulated in a practical formulation useful for sexologists by the International Society of Holistic Health (47).

Discussion

Men and women are psychosexually very different in accordance with their historical sex-roles. In the modern uni-sex culture, where both genders are taking all kinds of jobs and social functions we forget that sex is about biology and biology does not change as fast as culture. We therefore need to acknowledge nature and respect the differences of male and female. One of the most important differences seems to be the female's need for respect, safety, security and care, to open up emotionally and sexually. Sexuality is often quite mechanical for a man; a tight vagina is to some extent what he always dreams about. The woman's sexual dreams are much more romantic, and sexuality is really rewarding without a deep feeling of love and devotion.

The sexologist must understand these differences, and train the two genders to understand and respect each other. Interestingly most male sexual dysfunctions, erectile impotency, and premature ejaculation, come directly from emotional problems in the relationship, the man feeling insecure and uneasy in the sexual situation. In the same way most female sexual dysfunction comes from her partner not holding her emotionally and spiritually also; even the hardest and most persistent penetration is rarely enough to bring her to high levels of pleasure and orgasm; often insensitive penetration is actually the direct cause of sexual pain, making about half of the world's women complain about dyspareunia. Therefore correction of penile hardness with a drug like Viagra® is not the whole story.

Viagra® has become a money machine, because millions of impotent men desperately want to become sexually potent today. But keeping up appearances is not solving the sexual problems, which are not really inside the man, but lies in the interaction between the partners. The physician having the patient's confidence for a moment before prescribing Viagra can therefore help the male, who is in deep trouble by pinpointing the real problems. We all know that it takes one minute to prescribe a drug, but many hours to help a man solve his real problems. So the next time you think of prescribing Viagra® to a patient please consider the true needs of this man and his female partner.

When it comes to sexual dysfunctions talking is not enough, reviews have shown that bodywork is actually needed (48). Meston and Bradford (49) concluded recently that "medical treatments for women's sexual dysfunctions have largely failed to outperform placebo treatments but may be useful in specific clinical subgroups" and "despite widespread clinical acceptance in many cases, few psychosocial treatments for women's sexual dysfunction are empirically supported. Little is known about which treatment components are most effective" (49).

Marinoff and Turner (50) concluded already in 1991 that "too often patients with vulvar symptoms are shunted from one gynaecologist to another and finally told they should seek psychiatric help." Another thing that clearly does not help much in dyspareunia is antibiotic drugs, which are also often prescribed; the reason for this is simple: "Although some authors have proposed that the vulvar vestibulitis syndrome may reflect an infection agent such as *Candida albicans*, our results showed little evidence of an infections etiology, even after multiple samplings at various sites... We found that dyspareunia was present at first intercourse in 44% of the patients, suggesting a primary form of this syndrome in a relatively large proportion of affected woman (51).

The more "sterile" and orderly, mechanical type sexological treatment is also inefficient: "Approximately 15% of woman have chronic dyspareunia that is poorly understood, infrequently cured, often highly problematic and distressing. Chronic dyspareunia is an urgent health issue...the traditional treatment of vaginismus with vaginal "dilatation" plus psycho education, desensitisation, and so forth is not evidence-based... Pelvic floor therapies for dyspareunia may be effective" (52). Schultz's group (52) were very positive to the "educational gynaecological sexological examination": "When conducted correctly, it can be highly therapeutic." "Through this examination, the foundation is laid for a meaningful discussion afterwards, in which all the findings are explained and at which time further sexual complaints may come to light..." (52).

Schultz et al (52) concluded: "Ideally a multidimensional, multidisciplinary approach for sexual pain is recommended, with attention to the following areas: the experience of pain, the emotional/psychological profile, any context of past mutilations or sexual abuse; the genital mucose membrane; the pelvic floor; and sex and partner therapy...Psychological issues (as well as interpersonal issues) should be addressed early on with psychotherapy" (52).

Rosenbaum and Owens (38) concluded: "Physical therapy treatment of pelvic pain is an integral component of the multidisciplinary approach to chronic pelvic pain and associated sexual dysfunctions (38). There thus seem to be an agreement among the researchers that manual sexological treatment is needed for curing sexual dysfunctions. Conversation therapy cannot do this alone. Pharmacological treatment is also not always helpful and neither is psychiatric treatment. And very few believe surgery to be the answer to genital pain.

Conclusion

Researchers seem to agree that manual sexological procedures combined with conversation therapy is the cure of choice in most sexual dysfunctions. Couple therapy is often recommended. Erective dysfunction can be symptomatically treated with Viagra®, but we do not believe this to be a good solution for the female partner, and therefore not for the couple.

We do not believe it to be helpful at all in the long run. The reason is erectile impotency mostly is caused by emotional problems and lack of emotional contact with the female partner and that mechanical penetration without emotional contact is the primary cause of female dyspareunia. Sexual intercourse is a mutual thing; only when the sexual interaction is emotionally and spiritually deep and energetically dynamic can both participants reach optimal sexual pleasure and full orgasm.

The sexologist must have more than a mechanical approach to sexology; it takes a fully developed holistic approach to give the necessary attention to all relevant aspects of the human being - body, mind and spirit - to help a couple reach the highest levels of sexual pleasure. Very often both somatic and psychiatric problems are solved in this process of sexual healing. The patient's psychosexual development and the whole field of sexology therefore seem to be of utmost importance in medicine.

Sexual problems are almost always caused by emotional problems, which cannot be solved with a drug. Sexology must focus not only on the genitals, but also on the whole person. Developing on the patient's understanding of the different natures of male and female and involving the partner in the solution of sexual problems are indispensable steps in the healing of sexual dysfunctions.

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The life mission theory revisited - Understanding existential healing in sexology

Genetic factors, external stress and the human factor are influential in the health and well-being of every person. Several studies have shown that the human being have many internal powers that can promote health and increase quality of life. A theory on the human meaning of life is put forward and how it relates to health, disease and quality of life in the context of holistic medicine.

Introduction

The basic factors that influence health and disease can be divided into three categories: genetic factors, external stressors and traumas, as well as positive factors such as social network and medical treatment, and finally the purely “human” factor concerned with lifestyles, free will, philosophy of life and the quality of their lives. Studies of the role of this “human” factor (1,2) indicated that many patients have major and unexplained powers to promote their own health. This short communication sketches a possible explanation that draws on classical psychodynamic and psycho-somatic theory.

The theory

The phases listed below chart the life and disease history of an individual (II-VII). At the outset, let us assume that a human being begins his or her existence with a plan or an ambition for a good and healthy life. We may put this assumption of a primordial plan in quite abstract terms:

I. Life mission. Let us assume that at the moment of conception all the joy, energy and wisdom that our lives are capable of supporting are expressed in a “decision” as to the purpose of our lives. This first “decision” is quite abstract and all-encompassing and holds the

intentions of the entire life for that individual. It may be called the personal mission or the life mission. This mission is the meaning of life for that individual. It is always constructive and sides with life itself.

II. Life pain. The greatest and most fundamental pain in our lives derives from the frustrations encountered, when we try to achieve our personal mission, be they frustrated attempts to satisfy basic needs or the failure to obtain desired psychological states.

III. Denial. When the pain becomes intolerable we can deny our life mission by making a counter-decision, which is then lodged in the body and the mind, partially or entirely cancelling the life mission.

IV. Repair. One or several new life intentions, more specific than the original life mission, may now be chosen relative to what is possible henceforth. They replace the original life mission and enable the person to move forward again. They can, in turn, be modified, when they encounter new pains experienced as unbearable. (Example: Mission #1: "I am good." Denial #1: "I am not good enough." Mission #2: "I will become good," which implies I am not).

V. Repression and loss of responsibility. The new life intention, which corresponds to a new perspective on life at a lower level of responsibility, is based on an effective repression of both the old life mission and the counter-decision that antagonises and denies it. Such a repression causes the person to split in a conscious and one or more unconscious/subconscious parts. The end result is that we deny and repress parts of ourselves. Our new life intention must always be consistent with what is left undenied.

VI. Loss of physical health. Human consciousness is coupled to the wholeness of the organism through the information systems that bind all the cells of the body into a unity. Disturbances in consciousness may thus disturb the organism's information systems, resulting in the cells being less perfectly informed as to what they are to do where.

Disruptions in the necessary flow of information to the cells of the organism and tissues hamper the ability of the cells to function properly. Loss of cellular functionality may eventually result in disease and suffering.

VII. Loss of quality of life and mental health. In psychological and spiritual terms, people who deny their personal mission gradually lose their fundamental sense that life has meaning, direction and coherence. They may find that their joy of life, energy to do important things and intuitive wisdom are slowly petering out. The quality of their lives is diminished and their mental health impaired.

IX. Loss of functionality. When we decide against our life mission we invalidate our very existence. This shows up as reduced self-worth and self-confidence. Thus, the counter-decisions compromise not only our health and quality of life, but also our basic powers to function physically, psychologically, socially, at work, sexually, etc.

Applying the theory

Spiegel et al (1) asked women with metastatic breast cancer to talk to each other in group sessions about their illness. As described in the article, the women made an effort to improve the quality of their lives. Survival improved radically, relative to a control group. This may be accounted for as follows. When people confront and deal with still more of their destructive

cognitions or attitudes to life, then the counter-decisions recorded in their bodies and minds results in the repressed pain to resurface in consciousness to be dealt with and the fragmentation of the person slowly ceases. We heal and we become whole. Since the fragmentation is one of the causes of the disease resulting in decreased quality of life and ability to function, the internal repair will enable the person to become more healthy, happy and functional. The inner qualities of joy, energy and wisdom re-express themselves. Other things being equal, there will be prophylactic effects on new outbreaks of disease, accidents and loss of functionality.

Ornish et al (2) induced patients with coronary arteries severely constricted from atherosclerosis to adopt lifestyle changes and deal with the quality of their lives. This had beneficial effects on the arterial constrictions, as compared with a control group.

The life mission theory may explain this by reference to the systematic efforts exerted by the patients to modify their behaviours and the attitudes that go along with them. This means that people work to relinquish destructive attitudes to life that deny the life mission. As this denial recedes, the person more or less returns to his or her natural state of health, quality of life and ability to function.

The theory predicts that, for example, that when a person is helped along by a family physician conducting a conversation (clinical interview or consultation) about the quality of life of that person, she can re-establish her life mission. The person can then recognize it as the proper purpose in her life. She can rearrange her life accordingly and achieve her truest sense of humanity, a human being in full agreement with herself and life. This person can draw on her resources and potentials to the fullest degree. In her natural state, a human being is maximally valuable to herself and the world around her.

A consciousness-oriented (holistic) medicine based on this theory will help people become valuable not only to themselves, but also to each other.

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Sexuality and quality of life in Denmark

In a large representative sample of 2,460 Danish citizens aged 18 to 88 years anonymous answers were obtained to a 317-item quality of life (QOL) questionnaire, which included five questions on sexuality. Among the respondents in the sample, 1.2% reported they were bisexual and 0.9% homosexual. Although sexual problems were found in all age groups, lack of a suitable sex partner and inability to achieve orgasm were more common among the young and erectile dysfunction more common among the old. Most frequent problems among the women were reduced sexual desire (11.2%) and the lack of a suitable sex partner (4.9%), and among the men, the lack of a suitable sex partner (7.3%) and erectile dysfunction (5.4%). The QOL of persons with sexual problems was from 1.2 to 19.1 % lower than the population mean (as expressed in terms of this mean). The intermediate sized covariation between sexual problems and the QOL suggested that such problems can be symptoms of a reduced QOL rather than medical problems to be tackled through medical intervention or sex therapy proper. Implications for a quality-of-life-sensitive clinical practice are discussed.

Introduction

Sexual problems are common in most populations and depending on cultural norms they surface intermittently in the family practice setting (1). Nevertheless, population surveys examining the incidence of sexual problems are comparatively rare and studies of their relation to the quality of life (QOL) of those experiencing the problems are virtually nonexistent.

Research examining the occurrence of sexual problems in nonclinical populations tends to be restricted to highly select populations (2), such as healthy women in an outpatient gynecological clinic (3), normal married couples (4,5), young married couples with children (6), sexual dysfunction in middle-aged men (7) and women (8), with samples of 38-439. A review of 23 "community samples" reported a frequency of 4-10% (male, female) for difficulty in achieving orgasm, 4-9% for erectile problems (M), and 36-38% for premature ejaculation (M). It is difficult to obtain an overview of the prevalence of sexual dysfunction from the international literature. Only somatic dysfunctions are well defined, while

predominantly psychologically conditioned dysfunctions appear under a multiplicity of labels in the various investigations.

Overall, it appears that between a fifth and half of the respondents experience minor sexual dysfunctions, such as lack of sexual interest or difficulty achieving orgasm, whereas less than 10% of the population suffer from major dysfunctions, such as vaginismus or erectile problems. Sexual problems often coexist with other problems, such as depression, lack of self-esteem, problems with relationships, or just inadequate sexual experience. Nevertheless, very little is known about the relationship between sexual problems and the QL.

In connection with a follow-up study of the Copenhagen Perinatal Birth Cohort 1959-61 we contacted 7,222 men and women, 31-33 years old born at the Copenhagen University Hospital during 1959-1961 (9) and identified a representative sample of 2,460 Danes ages 18-88 years for comparative purposes (10) that will be presented in this chapter.

Our population survey

A representative sample of the Danish population was taken from the CPR Register (the Danish government agency registering all Danish citizens) by selecting a particular date in the year and then selecting all persons born on that date from 1904 and every fifth year thereafter until 1974 (the year 1961 was also included to obtain a group of 31-year-olds for comparative purposes). In all, 2,460 persons were sent an anonymous questionnaire. A reminder was mailed a month later and 1,494 usable responses were obtained (male = 741, female = 753), corresponding to a response rate of 60.7%. The response rate for each individual question was typically a few percent lower.

The questionnaire designed for this research contained 317 questions grouped into sections entitled social data, lifestyle, illness, sexuality, self-perception, view of life and values, as well as five series of questions measuring the QOL. The section on sexuality included the following questions (the response options given are stated in the parentheses):

- "Are you sexually active?" (yes, no).
- "How satisfied are you with your sex life now?" (very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied).
- "Sexual orientation" (heterosexual, bisexual, homosexual).
- "Do you have sexual problems?" (no; yes, but they are not associated with any prolonged illness or disability; yes, and they are associated with a prolonged illness or disability).
- "If yes, is your problem (circle a reply in each line): lack of a suitable sexual partner; reduced sexual desire; pain or discomfort during intercourse; unable to achieve orgasm; decreased ability to achieve erection (male); premature ejaculation (m); involuntary vaginal spasms severe enough to prevent intercourse (vaginismus) (female); other?" (yes, not sure, no).

The theoretical basis for the QOL measurement was an integrative QOL theory (11). It organizes eight individual theories of QOL into a spectrum ranging from subjective (self-

evaluated) to objective (externally evaluated) QOL and spanning a core of theories that consider QOL as deriving from human nature or human existence itself (existential theories).

These eight theories or dimensions of the QOL were operationalized into eight QOL rating scales, which were grouped into three kinds:

- Subjective dimensions. (i) Immediate, self-experienced well-being; (ii) Satisfaction with life; (iii) Happiness.
- Existential dimensions. (iv) Needs fulfilment; (v) Subjective experience of objective temporal domains (family, work, leisure); (vi) Subjective experience of objective spatial domains (satisfaction with social relationships); (vii) Expression of life's potentials.
- Objective dimension. (viii) Objective factors (income, employment, education etc).

Eighty-five of the questions were used to measure the QOL along these eight dimensions. The measurement scale used a Likert scale with five response options symmetrically arranged around a neutral midpoint. As an example, well-being is measured by the question "How are you feeling now?", and the response options given are very good, good, neither good nor poor, poor, very poor. By using a central and precisely worded midpoint (neither good nor poor), the response options symmetrically aligned up and down the scale (good, poor) and the use of the same amplifier (very) we constructed a classical Likert-scale which we consider equidistant (11). If an underlying scale is selected that ranges from 0 to 100%, from the worst imaginable to the best imaginable QL, the five response options may be reasonably positioned at 10, 30, 50, 70 and 90%. In other words, if a respondent checks good, his or her well-being is measured at 70%. In this manner, an approximated ratio scale was obtained (9), such that means could be computed and compared. A weighted mean for the eight QL dimensions was computed by way of means for the subjective and existential measures, respectively. The resulting overall measure is global (covers all aspects of life, not merely health-related aspects) and generic (not disease-related or intended for a specific category of patients).

Significance levels for the relationships between each variable and the measured QL were computed for the continuous variable using classical correlation and a modified regression described in Ventegodt (9), while in the case of the discrete variables every group (type of sexual problem, etc.) was tested, using the Wilcoxon test, individually against the rest of the sample $H_0: \mu_i = \mu_{\text{non-}i}$, i.e., the null hypothesis that the mean QL of a particular group (e.g., those with a reduced sexual desire) is significantly different from the mean QL for the rest of the population i.e., those that do not experience reduced sexual desire.

In the tables, information on QL and sexual satisfaction from these eight dimensions (rating scales) are given along with the total QL score.

The validity of the questionnaire has been examined (9), and the measurement instruments (the rating scales) proved valid and sensitive to a degree matching that of commonly recognized international instruments.

A 1-month and a 3-month test-retest for reproducibility showed correlation coefficients for the eight instruments ranging from .6 to .9. A qualitative assessment of the validity of the questionnaire was performed, in which 80% of the respondents indicated that the questionnaire items expressed all dimensions relating to their quality of life, 17% were in doubt, and 3% felt they did not-which was found acceptable.

What did we find?

We found that 81% of the respondents in Denmark were sexually active with a decrease to 63.7 % in the top age bracket. Persons without a sex life had a QOL considerably lower than persons with a sex life, the former had a QOL 13.8% below the population mean (see tables 1 and 2). On the whole, this value did not change with the age of the respondent. It should be noted that since two of the QOL dimensions (expression of life's potentials, and objective factors) presuppose the presence of a partner, the low QOL measured here may be attributable to the absence of a partner among the sexually inactive. However, the dimensions that did not presuppose a partner, such as well-being, satisfaction with life and happiness were similarly related to sexual activity, since persons without a sex life have a QOL 7.3, 7.4 and 9.3% respectively below the population mean in these three dimensions.

Table 1. Population frequency and overall quality of life among different groups (579 females; 605 males)

Group	Population frequency % Overall QOL (weighted)				p values	
	F	M	F	M	F	M
Heterosexual	98.1	97.7	69.7	69.5	0.004	0.004
Bisexual	1.0	1.3	75.2	62.1	0.08	0.08
Homosexual	0.9	1.0	67.2	55.5	0.02	0.02
Population Mean			69.7	69.3		

Altogether, the magnitude of the relationship between sexual activity and OL is classified as "intermediate."

Sexual orientation

Few bi- and homosexual persons were found in the sample: 1.2% reported they were bisexual and 0.9% homosexual. Similarly low numbers were found in the aforementioned cohort of 7,222 (11); among women were found 1.6% bisexual and 1.4% homosexual persons, and among men 1.3% bisexual and 1.1% homosexual persons. These remarkably low numbers contrast with traditional estimates, e.g., those of the Kinsey report and the often cited 10%, as well as results like 2-4% homosexuals among married men (12).

The question about sexual orientation was skipped by more respondents than most other questions, and these nonreporters may of course be bi- and homosexual. However, an analysis of the problem indicated that about 10% of the Danish population are unsure about the meaning of "heterosexual".

Satisfaction with sex life

Satisfaction with sex life varied a little according to gender, but showed no significant correlation with age: 66.7% of the women and 57.5% of the men indicated they were satisfied

or very satisfied with their sex life, while 11.3% of the women and 18% of the men were dissatisfied or very dissatisfied (see table 3).

The covariation between the degrees of satisfaction with one's sex life and the measured QOL was considerable (Women $r = .43$ $p < .0001$).

Female sexual problems

Sexual problems are distributed unevenly among the genders, reflecting the different anatomy and psychology. Among females, reduced sexual desire was the most common problem (11.2%) varying little with age (see table 5).

These women experienced a subjective QOL somewhat lower (7%) than that of the population as a whole, but their overall QOL was only a few percent lower than the population mean. 4.9% indicated they lacked a suitable sexual partner and this figure hardly varied with age. These female's overall QOL was 17.2% below the population mean (9.9% when controlled for the two QOL dimensions that presuppose a partner). Inability to achieve orgasm was indicated by 6.8% of the females. It is slightly more frequent among the young and decrease somewhat with age. The QOL of these women was 4.4% below the population mean. Pain or discomfort during intercourse was reported by 3.1%, while vaginismus occurred in 0.5%. The QOL of these two groups was 5.9 and 8.6%, respectively, below the population mean.

Summarizing, the females reported somewhat fewer sexual problems with age (see table 6). Reduced sexual desire was by far the most prevalent sexual problem among the women. To identify the most serious problem, the difference in QOL between the population and each group of females with a particular problem may be used. Without venturing any causal claims, we thus conclude that among the sexual problems included here, the lack of a suitable sexual partner was the most important correlate of a poor QOL.

Male sexual problems

Among the males, the lack of suitable partner was the most frequently occurring problem, as reported by 7.3%. This problem decreased with age. The QOL of this group was measured to be 20.2% below the population mean (13.2% if the figure is computed without the two QOL dimensions that presuppose a partner, as above). The most frequent sexual problem was premature ejaculation (4.9%), a problem that seems unrelated to age. The QOL of this group was 1.8% below the population mean. Reduced sexual desire is reported by 3.2% of the men, and their mean QOL is 6.9% below the population mean. Decreased ability to achieve erection is found among 5.4% of the males and this group was 3% below the population mean in overall QOL. This problem increased with age. Discomfort or pain during intercourse was reported by 0.4% of the males. The QOL of this group was measured to be a considerable 6.7% below the population mean. Inability to achieve orgasm was rare among males (0.8%) and the mean QOL of this group was 5.2% below the population mean.

Summarizing, the most prevalent and serious sexual problem for males was the lack of a sexual partner.

Table 2. Sexual orientation and quality of life as measured in each dimension

	Quality of life in eight dimensions ^a															
	1		2		3		4		5		6		7		8	
Group	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Heterosexual	71.9	72.5	69.2	69.5	66.1	65.3	69.2	68.6	75.7	75.9	69.3	68.6	62.1	61.8	70.9	70.8
Bisexual	76.7	65.0	73.3	60.0	63.3	60.0	76.7	63.9	77.8	73.8	69.3	67.3	67.9	53.0	81.4	60.2
Homosexual	82.0	56.7	78.0	53.3	70.0	50.0	74.0	56.0	79.3	62.2	66.4	60.7	56.4	49.1	56.0	56.1
Population mean	72.0	72.3	69.3	69.2	66.1	65.1	69.4	68.5	75.8	75.7	69.3	68.5	62.2	61.5	70.9	70.5

^a1. Immediate, self-experienced well-being; 2. Life satisfaction; 3. Happiness; 4. Fulfilment of needs; 5. Experience of objective, temporal domains (family, work, leisure); 6. Experience of objective, spatial domains (self, others, world); 7. Expression of life's potentials; 8. Objective factors.

Table 3. Population frequency (%) and stated satisfaction with sex life divided according to age^a

	Age group											
	18, 23		28, 31, 33		38, 43		48, 53				All	
	F	M	F	M	F	M	F	M	F	M	F	M
Very satisfied	28.0	22.7	26.6	19.3	27.0	19.9	24.0	25.7	27.8	16.9	26.4	20.6
Satisfied	37.1	31.9	40.4	31.7	40.9	44.3	43.2	38.5	40.2	40.0	40.3	36.9
Neither/nor	30.8	25.5	19.2	26.1	13.9	18.3	21.6	23.9	22.7	27.5	21.9	24.4
Dissatisfied	4.2	12.8	10.8	16.2	13.9	10.7	9.6	11.0	7.2	12.5	9.1	12.9
Very dissatisfied	0.0	7.1	3.0	6.8	4.4	6.9	1.6	0.9	2.1	3.1	2.2	5.1

^aAges are those derived from the sample. Females = 702; males = 605.

Table 4. Mean quality of life of respondents divided according to age and stated satisfaction with sex life^a

	Age group													
											58, 63, 68, 73,			
	18, 23		28, 31, 33		38, 43		48, 53		78, 83, 88		All		p values	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Very satisfied	71.9	72.3	77.0	77.2	80.0	79.0	77.8	77.4	70.1	78.2	74.3	75.1	0.0001	0.0001
Satisfied	67.4	69.2	72.4	72.2	73.5	74.9	72.8	73.0	66.4	69.9	69.5	70.5	0.0001	0.0001
Neither/nor	60.5	62.5	64.8	68.8	66.3	68.7	64.9	65.2	65.4	64.6	62.5	65.2	0.0001	0.0001
Dissatisfied	61.1	57.3	62.0	58.4	61.4	62.0	64.7	63.5	64.0	64.3	61.6	59.9	0.0001	0.0001
Very dissatisfied	0.0	54.0	69.5	48.7	52.5	56.1	60.0	66.83	59.4	67.7	59.5	54.4	0.0001	0.0001
Population Mean											68.3	68.0		

^aFemales = 702; males = 653. Ages are those derived from the sample.

**Table 5. Percentage of sexual problems among females divided according to age
(N = 686)**

Age group (years)	18-23	28-33	38-43	48-53	58-88	All	p value
No problems	77.4	72.5	73.2	75.2	87.9	70.3	0.01600
Lack of partner	5.5	6.0	5.4	6.6	2.8	4.9	0.33710
Reduced desire	6.2	13.0	17.0	14.0	10.3	11.2	0.57130
Pain/discomfort during intercourse	3.4	3.5	3.6	5.0	0.9	3.1	0.43000
Lack of orgasm	11.0	8.5	7.1	5.8	2.8	6.8	0.00670
Vaginismus	0.0	1.5	0.0	0.8	0.0	0.5	0.64210
Other	2.7	6.5	3.6	4.1	0.9	3.6	0.19620
Total	106.2	111.5	109.8	111.6	105.6	100.0	

Males $r = .51$ $p < 0.0001$) (Table IV) and, in relation to other correlation coefficients found in the survey, classified as "large."

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**Table 6. Mean quality of life of women divided according to sexual problem and age
(N = 686)**

Age group (years)	18-23	28-33	38-43	48-53	58-88	All	p value
No problems	66.7	72.9	75.2	73.0	67.0	71.2	0.0001
Lack of partner	55.3	63.6	46.3	58.8	53.3	57.3	0.0001
Reduced desire	71.5	66.4	66.9	69.2	62.4	67.5	0.0895
Pain/discomfort during intercourse	62.7	63.2	69.8	66.8	47.6	65.0	0.0763
Lack of orgasm	67.8	63.8	63.1	70.3	62.9	66.1	0.0222
Vaginismus	0.0	63.2	0.0	66.2	0.0	63.3	0.2189
Other	61.3	65.7	68.9	74.4	68.8	67.4	0.3190
Population mean						69.4	

Table 7. Percentage of sexual problems among males divided according to age (N = 626)

	Age group							
Years	18- 28	31- 33		48-53	58-88	All.	Correlation	p-values
No problems	81.4	75.7	89.3	83.0	76.6%	73.1	-0.37590	0.33090
Lacking suitable sexual partner	11.4	11.8	5.0	7.0	3.8	7.3	-0.11581	0.00270
Reduced sexual desire	1.4	4.6	3.3	0.0	7.0	3.2	0.06670	0.08300
Pain or discomfort during	0.7	0.0	0.0	2.0	0.0	0.4	-0.00549	0.88710
intercourse Unable to attain orgasm	0.7	0.7	0.0	1.0	1.9	0.8	0.04663	0.22770
Decreased ability to achieve	2.1	2.0	0.8	5.0	17.7	5.4	0.27868	0.00010
erection Premature ejaculation(m)	3.6	7.9	4.1	6.0	5.1	4.9	0.00322	0.93370
Other	2.9	3.9	2.5	4.0	1.3	2.6	-0.03937	0.30410
Total	104.3	106.6	105.0	108.0	113.3	98.0		

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Table 8. Mean quality of life of males divided according to sexual problem and age (N = 626)

	Age group						
Years	18-28	31- 33	38, 43	48-53	66-78	All	p values
No problems	67.2	71.3	74.0	72.5	70.2	71.2	0.0001
Lacking suitable sexual partner	56.8	51.3	53.1	58.0	55.0	55.2	0.0001
Reduced sexual desire	60.1	62.7	62.5	-	63.7	64.3	0.0132
Pain or discomfort during intercourse	47.4	-	-	72.0	-	64.6	0.5722
Unable to attain orgasm	47.4	71.4	-	64.6	69.0	65.4	0.3610
Decreased ability to achieve erection	60.0	75.2	45.1	61.6	68.1	67.0	0.2751
Premature ejaculation(m)	69.2	66.1	65.4	72.3	62.5	67.8	0.4934
Other	65.9	61.5	59.1	66.0	68.5	63.8	0.0337
Population mean						69.1	

Discussion

We found that 29.7% of the women and 26.9% of the men reported sexual problems. These numbers did not seem inconsistent with the trend from the research cited in the introduction. Erectile dysfunction showed increasing prevalence with age, while lack of a suitable sexual partner and inability to achieve orgasm decreased with age. Decreased sexual desire, pain or discomfort during intercourse and premature ejaculation showed no covariation with age. Only 2.4% of the affected group reported their problems to be associated with ill health. This means that sexual problems in the vast majority of cases occurred in persons otherwise healthy. Over a quarter of the respondents in this representative sample of the Danish population reported sexual problems. Some problems varied with age and in most of these people, the sexual problems were not associated with any disease or condition, suggesting that the problems were likely to remain undiscovered during a regular consultation. Regarding their QOL, the group of persons with sexual problems scored about 10% below the population average. One implication of this finding could be that physicians seeing patients with indistinct complaints or general feelings of discomfort should be attentive to possible sexual problems. Of course, one cannot attribute a poor QOL to sexual problems. It is equally plausible that a low QOL is a harbinger of many problems, including sexual ones.

The found correlation between sexual problems and relationship to partner ($r = .3$, $p \leq 0.0001$) suggested that an approach focusing on the patient's relationship with his or her partner may be useful. Sexual problems that reveal themselves in the clinic may thus be taken as an opportunity to tackle relationship problems. In many cases, a better relationship with one's partner may lead directly to the solution of many sexual problems.

Sexual problems seem widespread in the population and they showed some measure of covariation with the quality of life. It is unclear whether sexual problems lead to a poor quality of life, or a poor quality of life leads to sexual problems. Thus, the safe course of action for the physician is to be attentive to sexual problems. It is noteworthy that some sexual problems abate somewhat with age, especially among women. This does not necessarily mean that their problems receive treatment or are otherwise solved, but they may be settled in such a way that each person finds a way to live with them. In the domain of sexual problems, the general practitioner may be well advised to proceed with caution and to take his or her starting point in the quality of the patient's life as a whole and the common problems that it presents.

Acknowledgment

This chapter is based upon an earlier paper: Ventegodt S. Sex and the quality of life in Denmark. *Arch Sex Behaviour* 1998;27(3):295-307.

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Traumatic life events and later quality of life

Sexual life events are known to be some of the most traumatic of all types of life events. To assess the size of the impact of sexual life events compared to all other life events we have screened a large group of 55-66 years old people for all kinds of traumatic life event and measured their subsequent self-assessed quality of life.

In the chapter we examine associations between global quality of life (QOL) and major life events in a retrospective study using the self-administrated expanded SEQOL questionnaire with questions on life events and connected emotions. 746 people, 55-66 years old from a representative sample of the Danish population were used. Global QOL, measured by SEQOL (self evaluation of quality of life), containing eight global QOL measures: Well-being, life-satisfaction, happiness, fulfilment of needs, experience of temporal and spatial domains, expression of life's potentials and objective factors were administered. We found that life events related to health such as restraints of movement or psychological illness showed a major association with the quality of life. Most other associations between quality of life and life events were intermediate or minor. Quality of life cannot simply be determined by life events. Actual quality of life is determined by how all the events of life have been processed and integrated in the consciousness. The results seem to support the idea that global QOL can be efficiently improved by integrating the painful events of the past. Since several studies have shown correlations between QOL and health, it is likely that such an improvement of QOL will also cause improved health and ability.

Introduction

Quality of life (QOL) has become an important topic in the public debate (1-3) and it is more and more considered to be important in treating and preventing illness and therefore been the subject of a number of philosophical and psychological studies (4-10). It is becoming increasingly apparent that illness is closely related to the concept of quality of life and therefore the exploration of indicators related to quality of life appears to be of broad importance for the prevention and treatment of diseases. Identifying which factors that constitute a good life may reveal an understanding about what areas in life that are to be

encouraged, in order to enhance the global quality of life. Following are the results from a study examining quality of life and major life events.

The hypothesis in our survey was that life is made up by our life events, or what happen to us during life and the situations we manage to create for ourselves. Behind this simple hypothesis lies the great philosophic dilemma that life does not consist of events, but of a continuum, a constant now.

Philosophically, to delimit an event is therefore very difficult while, paradoxically, the mind has no problem with cutting the world to bits and identify events, when these are defined in a questionnaire as for instance divorce, death, accident etc. One problem with events is when do they start? An example is a dismissal, which has been expected. From a psychological point of view, the event may actually begin with the expectation of a dismissal and this expectation may in actual fact make the event happen.

We consider the continuity of life to contain some traits, which by their importance defeats the events. Our awareness is a flowing continuum and all events are more or less accidental and more or less successful attempts by our mind to create order out of the chaos of reality. However, it will be carrying it too far to probe the philosophical difficulties surrounding the definition and delimitation of life events in this chapter. For all practical purposes life events are just as operational dimensions as they are unwieldy, even intangible and incomprehensible, when viewed philosophically.

The objective of our study was to evaluate the associations between quality of life and major life events. We wanted to discover whether previous events in life have an influence on the present global quality of life, and the importance of the way in which the events are integrated in the mind.

The study was a part of a larger investigation of life events influence on quality of life; hence, in another study we look into factors connected to early life factors (11-13).

Our study

This study was built on a retrospective study, consisting on answers from 746 people, 55-66 years old in Albertslund, Denmark, a Copenhagen suburb in many ways representative of the Danish population.

Several measures have been constructed in order to measure people's quality of life, and these include many different approaches to the concept. To explore the association between quality of life and the major events in life, we created the comprehensive SEQOL questionnaire, which describes people's life, lifestyle, and quality of life (15-23). The SEQOL questionnaire is a self-administered questionnaire with items rated on a five-point Likert scale.

The questionnaire consists of 317 items based on an "integrative" theory of the quality of life meaning that it organizes a number of theories on the quality of life into a spectrum that spans the extremes of subjective and objective quality of life. These measures are showed below (sample questions from the questionnaire included). For further details concerning the questionnaire we refer to previous studies of the validity of SEQOL (15-23).

Subjective measures

1. Immediate, self-experienced well-being ("How are you feeling?")
2. Life satisfaction ("How satisfying is your life?")
3. Happiness ("How happy are you at present?")

Existential measures

4. Fulfilment of needs (e.g., "How well are your social needs fulfilled?")
5. Experience of life's temporal domains (e.g., "How do you feel when you are at home?")
6. Experience of life's spatial domains ("How satisfied are you with [each of five domains: self, partner, family, friends, community]"?)
7. Expression of life's potentials [some 30 questions on extent to which they are fulfilled]

Objective measure

8. Objective factors [some 80 questions on income, status, work etc.]

Replies to each of the questions that constitute these measures were weighted and scored to yield computable numbers between a minimum of 0 and a maximum of 100. These numbers were then taken as representing the quality of life of the respondent, expressed in terms of the eight different ways the quality of life has been measured by the questionnaire. Suitably weighted and scored, replies to the first part of the questionnaire constitute variables, the co-variation of which the quality of life can be calculated.

Measuring quality of life has been the subject of disagreements through time. In our research, the global QOL - in the most broad and all-including sense - is the primary outcome measure (dependent variable). The integrative QOL theory made us include 113 items from the SEQOL questionnaire for the calculation of the global QOL (23).

In this study we had to deal with an essential problem: When the statistical connection between 113 life factors and the global QOL was measured, we often had a contribution to the statistical co-variation from the construction of the global QOL measure. This problem turned out to be of little significance, as even the most strongly "constructed" connections did not count for more than 1/15th of the total connection. Still this gave an error of up to 7% in co-variation. As the large connections in our study showed a co-variation of 20% global QOL or more, the error mentioned above introduced by the construction of the global all-including QOL measure was generally neglectable. It is important to notice that the way our QOL measure was constructed does not constitute a measuring problem; we will almost always find a high correlation when $N=5-10,000$ between QOL and the many factors constituting the global QOL or the factors related to them. However, we are not looking at the size of the correlation (the statistical significance), but at the size of the statistical co-variation (QOL difference in %) showing the clinical significance.

For validation SEQOL was send together with the Nottingham Health profile (NHP) and Sickness Impact Factor (SIP), and the test-retest reliability correlation was > 0.8, Cronbach’s alpha was 0.75, correlation (r) to NHP was 0,49, to SIP 0.27 (P<0.05). Adjustment for health status made the correlation to SIP stronger among the sick (r=0.41). For SEQOL 111 respondents were needed to detect 3% difference in QOL. SEQOL are thus valid as it showed a high level of reliability, sensitivity and consistency.

Table 1. Single events

The connection between global QOL and 1000 different life events; only statistically (p<0.05; NS: Not significant) and clinically significant factors listed. Difference in global QOL is measured according to the Integrated QOL theory (Ventegodt et al, 2003j), and is measured with the validated SEQOL questionnaire (Ventegodt al, 2003f).	
*Difference in percentage between the worst and the best off (single events), or calculated with the method of weight modified linear regression (impact of all events) (Ventegodt and Merrick, 2003e).	
Life Event (impact of single event) QOL-difference (%) *)	
Conversion to a new religious belief	-21.7
Unable to walk	-21.1
Sexual assault by well-known offender	-20.8
Threatened with violence upon family	-18.6
Diagnosis: Lupus	-17.6
Psychotherapy in two periods	-16.4
Victim of rape	-15.7
Incest, without intercourse	-15.4
Invalidity pension	-15.3
Sexual assault: Pawing	-13.9
Paralysed, damaged or lack of body parts	-13.9
Catholicism	-13.0
Expulsed from a group	-12.9
Lack of care in childhood	-12.3
Attempt of rape, 1st time (women)	-12.1
Two psychiatric hospitalisations	-11.9
Registered in a credit-bureau	-11.9
Cannot run	-11.9
Venereal diseases	-11.6
Other serious physical disorders	-11.5
Unrealistic re-payment arrangement	-11.3
Peak experiences: Survival journey	- 11.3
Got kicked under attack	-11.2
Former an atheist, but now a believer	-11.0
Sex harassment	-10.8
Suddenly becoming abandoned by a close friend	-10.8
Fear of death	-10.8

Personal growth: fasting	10.5
Brain bleeding	-10.3
Debts to the public authorities	-10.3
Communism (political standpoint)	-10.3
Arthritis (diagnosis)	-10.3
Owing money, going to Bailiff's court	-9.8
1st. psychiatric hospitalisation	-9.5
Neurosis (diagnosis)	-9.3
Was adopted	-9.0
Peak experience: Out of your body/ synchronicity/psycho kinesis	8.9
Use of drugs as a life event: Tranquillisers	-8.7
Cannot go up/down stairs	-8.7
Meeting with Bailiff	-8.3
3rd. medical hospitalisation	-8.3
Lack of psychological contact with parents	-8.1
Early retirement pension	-8.1
A [former] period with good friends	-8.1
Use of drugs as a life event: Sleeping pills	-7.9
Social Security benefit	-7.8
Psychoactive drugs, 1st. period	-7.7
Lack of physical contact with parents	-7.7
Cannot lift heavy things	-7.7
Removal of birthmark	-7.7
Period with strong religious doubts	-7.6
Bad blood circulation	-7.5
2nd. medical hospitalisation	-7.4
Chronic bronchitis (diagnosis)	-7.4
Partner died	-7.2
Period of alcohol abuse	-7.2
Had a relationship with a much younger partner	-7.1
Money: Lost in properties	-7.0
Hobbies: Zoology	-7.0
Sexual assault: Obscene remarks	-6.9
Abdominal disorders	-6.9
Experienced a life crisis	-6.7
The partner left	-6.6
Perfectly tuned relationship with partner	6.5
Depression (diagnosis)	-6.3
Partner fails utterly	-6.2
Period with a great sense of loneliness	-6.2
Cheated (first time)	-6.1
Experience of the world falling apart	-6.1
Job offer/job training	-6.0
Illnesses of the back	-6.0
Serious crisis between oneself and mother/father	-5.9

Table 1. (Continued)

Been officer in the army	5.8
Sexual assault: Exposed naked	-5.8
Unemployment in two periods	-5.8
To be let down by a close friend	-5.6
Experienced someone death by suicide	-5.5
Hypertension (diagnosis)	-5.5
Sports: Running, marathon or similar	5.4
Scold ones children often	-5.0
Likes: New Age (music)	-5.0
Father/mother moved away	-5.0
3rd. surgical hospitalisation	-4.9
Suffered from a serious physical illness	-4.5
Had a relationship with a much older partner	-4.3
Pneumonia (diagnosis)	-4.2
1 or more divorces	-4.1
State of perfect balance in your life	3.9
Human relations with complete openness	3.9
Partner was unfaithful more times	-3.9
An experience of sudden, deep insight	3.8
Serious crisis with child	-3.7
1st. medical hospitalisation	-3.7
Perfect part of a community	3.5
Diminished acoustic capacities	-3.3
Using pain-killers (self-bought)	-3.1
Socialist People's Party (political standpoint)	-2.8
1 or more crisis in ones partner relationship	-2.8
Paralysed, damaged or lack of body parts	-2.8
Joined a political party	2.7
Incurable cancer (including skin cancer)	-2.6
Money: can afford to do what you want	2.5
Liberal (political standpoint)	2.5
2nd. surgical hospitalisation	-2.3
Always been a believer in good	2.1
Done military service	2.0
Sports: Swimming athletics, cycling or similar	1.9
Been in complete control of your economy	1.5
Interest: for food/wine	1.3
Sports: Trekking	1.2
Devoting yourself to your work completely	1.2
Very interested in theatre	1.1
Became a father/mother	1.1
First marriage	0.7

Our findings

As expected, life events related to both physical and psychological illness showed major associations with the quality of life; this was measured in terms of symptoms, hospitalisations and emotional thoughts. However most other isolated associations were intermediate or minor as seen in life events related to economy, employment, friends or relationships, experiments with personal development, military events, peak experiences, political affiliations etc. Table 1 shows the connection between single events and global QOL; a connection of 10% or more is considered to be clinically significant, while a connection smaller than 10% is considered “small”, according to ordinary practice in the Danish Quality of Life Survey (11-14). The clinically significant connections can be organised in eight groups as follows:

- Personal growth peak experiences: Survival journey (+11,3%), Personal growth: Fasting (+10,5%)
- Religion conversion to a new religious belief (-21,7%), Catholicism (-13,0%), Former an atheist, but now a believer (-11,0%)
- Sexual assaults: Sexual assault by well-known offender (-20,8%), victim of rape (-15,7%), incest, without intercourse (-15,4%). Sexual assault: Pawing (-13,9%); attempt of rape, 1st time (women) (-12,1%), sexual harassment (-10,8%)
- Physical health: Unable to walk (-21,1%), lupus ulcer (-17,6%), paralysed, damaged or lack of body parts (-13,9%), cannot run (-11,9%), venereal diseases (-11,6%), other serious physical disorders (-11,5%), brain bleeding (-10,3%), arthritis (diagnosis)(-10,3%)
- Social problems: Threatened with violence upon family (-18,6%), disability pension (-15,3%), expelled from a group (-12,9%), got kicked under attack (-11,2%), suddenly becoming abandoned by a close friend (-10,8%), communism (political standpoint) (-10,3%)
- Mental health psychotherapy in two periods (-16,4%), two psychiatric hospitalisations (-11,9%), fear of death (-10,8%)
- Lack of care in childhood lack of care in childhood (-12,3%)
- Financial problems registered in a credit-bureau (-11,9%), unrealistic re-payment arrangement (-11,3%), debts to the public authorities (-10,3%)

In the category “personal growth” we found experiences connected with improvement of QOL; in the category “religion” we found a strong negative connection between religious doubts and change of religion or change to religion from being an atheists; in the category “sexual assaults” we find a strong connection between these events and QOL; loss of physical health was also connected to significantly lower QOL; social problems (including communism which here was seen as dissatisfaction with society), mental health problems, lack of care in childhood and financial problems were also connected with lower QOL.

Strong connections with global QOL were generally not seen in the midst of single events; large associations in this study appeared when the events were analysed collectively. In the high level analysis we found strong associations between global QOL and the most dominant feeling and the level of integration of events. In general, people feeling a specific negative feeling often have a poor QOL (25,4 % below the people normally feeling of

positive feeling) and bad integration of one’s life events had a substantial, negative impact on the quality of life (25,1% below the people with the habit of integrating their life events). These constructs predict the quality of life of a person; interestingly the results showed (see table 2), that QOL was not to a high degree a product of the number of good and bad life events in life, but rather it seemed to be the way in which the events were integrated that determined the global QOL.

Table 2. High-level analysis of QOL and life events

Analysis of the statistical connection between life events and QOL (impact of all events) (all p = 0.01)		
Most common emotion (on a positive-negative scale)	b	25.4
The average level of events not integrated	b	25.1
Level of integration of five-year-old life events	b	25.1
Number of essential physical health symptoms	c	-13.6
Very negative events arranged in order of time	c	12.2
Number of good events minus bad events	c	11.8
Number of life events not integrated	c	11.5
Number of very negative life events not integrated	c	10.7
The number of important, very negative events not integrated	c	9.9
Number of bad life events	c	8.8
Number of events containing good feelings	d	6.9
Number of life event	e	6.1

Discussion

To our knowledge, only very few studies have investigated the effects of major life events on the later quality of life. Conversely, it is more common to investigate the effects of life events on the later health status. In this study we found global quality of life (QOL) to be strongly associated with events related to both mental and physical health. As shown here, and in numerous other studies (24-36), health seemed to have considerable associations with the global quality of life. For example a British study of 300 persons showed, that quality of life in early old age appears to be influenced primarily by serious health problems (37), and another study of more than 9,000 people showed that self reported health problems accounted for a considerable part of the quality of life (38).

Many people blame their past for their poor quality of life, but our findings do not support this idea. Our results seem to indicate, that it is not the actual events in our past that determine our quality of life, but rather the way in which the events were integrated in the mind. This gives us foundation to describe means to promote the global quality of life and

hereby the overall health, or in other words to develop a more positive and responsible philosophy of life and integrating our past.

An interesting and highly relevant question is whether we can explain poor global QOL with single painful events or a chain of painful life events connected to a specific traumatic theme. If we look at the sexual assaults, we find that “sexual assault by well-known offender (-20,8%)” was more “damaging” than rape and incest (“victim of rape (-15,7%)”, “incest, without intercourse (-15,4%)”) and that fondling and attempt of rape and sexual harassment was almost as “damaging” as rape and incest (“sexual assault: pawing (-13,9%)”, “attempt of rape, 1st time (women) (-12,1%)”, “sexual harassment (-10,8%)”). Deep reflections on these findings and many more results (11-14) have lead us to the conclusion that we cannot really explain the low QOL of the people of the category “victims of sexual assault” by the assaults themselves. In a previous study, we analysed this problem in details as we interviewed a series of narcotics-prostitutes (14) and discovered that the girls assaulted and raped often were severely abused and neglected in their early childhood. Thus it it's much more likely that these painful events rise on the general background of vulnerability, inviting other people to disrespect their borders and integrity.

The causality of the results is in many cases unclear. Thus it is possible that the results of table 1 were only symptomatic; the more hurt and vulnerable you are, the more you will attract horrible events and the lower your QOL will be. Life events are thus consequences of your own negative attitude and belief, much more than it is an objective unlucky event hitting you by some statistical rate. In accordance with this train of thought, it is known that girls who have been raped once have a much higher likelihood of being raped again (37).

The findings of the high level analysis of this study were in agreement with the life mission theory (10), which states that health, happiness and ability comes from living the purpose of your life, accepting full responsibility for the suffering of life, thus taking full learning and avoiding repression and eventually succeeding in expressing the talents in your life. To do this, it is important to develop as a person into what is known as the natural condition, a condition where the person knows himself and use all his efforts to achieve what is most important for him. Our concept of holistic medicine and the holistic process theory of healing (40-43) and the related quality of life theories (23,44,45) declare that the return to the natural state of being with optimal QOL is possible, whenever the person gets the resources needed for the existential healing. The philosophical change of the person healing is often a change towards preferring difficult problems and challenges, instead of avoiding difficulties in life. The person who becomes happier and more resourceful is often also becoming more healthy, more talented and able of functioning (24-36,43-46).

One limitation is the retrospective design, which involves a possibility for recall bias. When people have to answer questions about their past, there is a possibility that they will not remember correctly or that they will for example understate unpleasant experiences. Therefore the results can be influenced by bias. In addition the statistical analyses are relatively simple, as no stratification was carried out. Therefore we cannot be sure of whether the results actually reflect other associations than the ones that appear in the tables. By use of stratification it would be possible to determine the true effect of each event, however we chose in this chapter to give a general view of all the life events, instead of using complicated statistical methods on a few life events. The sample size in this study is indeed adequate and in addition it was previously shown that the SEQOL is a valid instrument (15-23).

We conclude, and this seems to be backed up by our other studies (11-14), that it is our level of consciousness, responsibility and our general attitude to what happens to us, that determine our quality of life, rather than our luck or misfortune. It seems that the actual quality of life is determined by the diligence with which the events have been processed and integrated. The overall conclusions can be listed as:

- Quality of life cannot be explained solely by the bad life events that contain negative feelings.
- People who are good at processing the events in their life statistically possess a high quality of life.
- Processing a bad event remove the negative importance to the quality of life.
- Time only heals life's wounds, if negative experiences are processed.
- Many, small life events mean more to the quality of life than few and bigger events.
- Quality of life is not determined by the life's event in itself, but the way we relate to life.

Interestingly, to our knowledge, this is the first time that we face massive quantitative documentation for the rationale of therapy and holistic healing. For future research we suggest that prospective studies should be completed so that the respondents receive the same questionnaire every 10 years. This would allow the investigators to explore the associations over time and recall bias would be avoided.

Conclusion

Our results showed that we could explain about 25% of the global QOL from how effective the person in the daily practice integrate his or her life events. Learning from what happened and processing the emotions (so that no negative feeling is left behind), seems to be a precondition for a good and healthy life. It seems that we have given quantitative documentation for the effect and its use in therapy and existential healing.

The global quality of life is probably not a function of single events. Life events seem closely connected to QOL and health. Usually QOL and health are difficult to change, but this study showed that there are some factors related to QOL that actually seems changeable. A lot of people blame their past for their poor quality of life, but our findings did not support this notion. If you wish you can integrate your life events and get rid of the negative impact. QOL is created here and now by having a constructive and responsible attitude towards life, self and other. We can integrate our emotionally negative life-events and thus recover our character and natural state of being(existential healing). It seemed that QOL could be improved independent of any major life events. As we find a strong connection between QOL and health, we believe that QOL and existential healing can be used as medicine, improving self-evaluated mental and physical health and general ability of functioning.

If we look at the sexual assaults, we found that "sexual assault by well-known offender (-20,8%)" was more "damaging" than rape and incest ("victim of rape (-15,7%)", "incest, without intercourse (-15,4%)") and that fondling and attempt of rape and sexual harassment was almost as "damaging" as rape and incest ("sexual assault: pawing (-13,9%"); "attempt of

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Acknowledgment

This chapter is based on original ideas that were peer-reviewed and published earlier in Ventegodt S, Flensburg-Madsen T, Andersen NJ, Merrick J. What influence do major events in life have on our later quality of life? A retrospective study on life events and associated emotions. *Med Sci Monit* 2006;12(2):SR9-15.

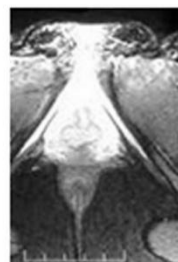
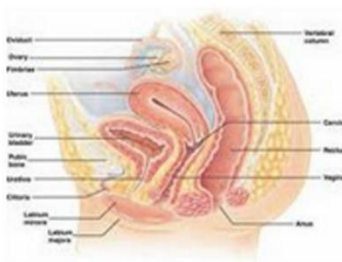
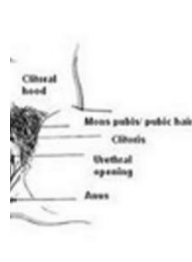
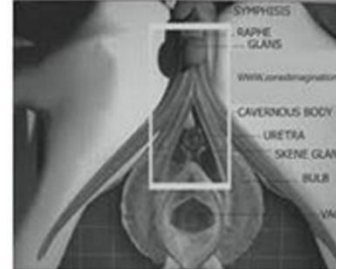
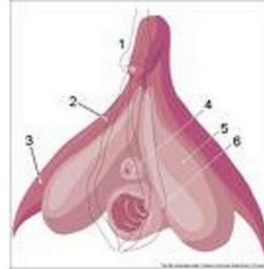
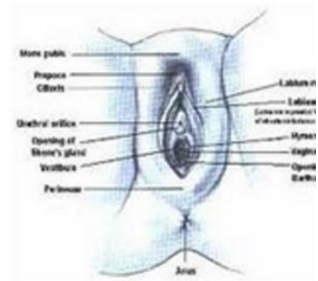
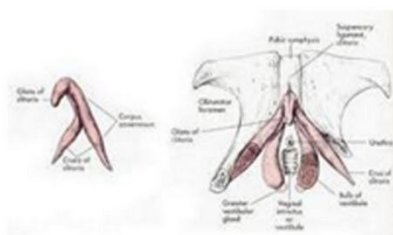
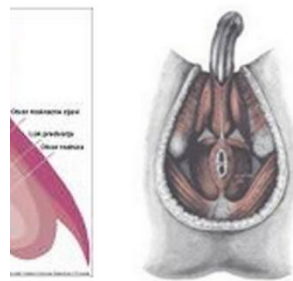
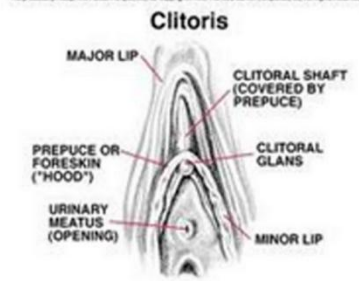
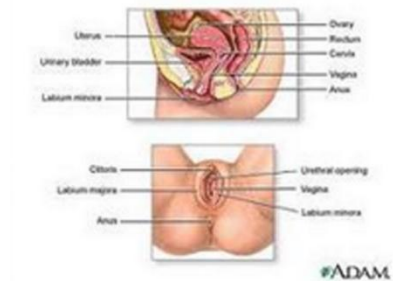
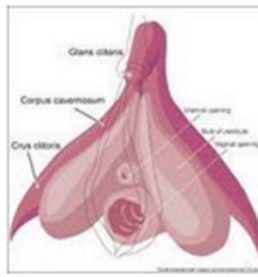
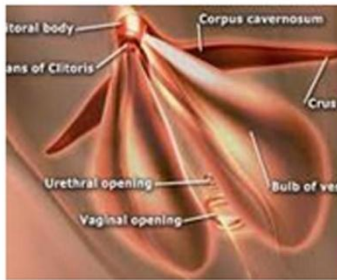
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AM



Female sexual problems and quality of life

In a study we tested the quantitative effect of classical holistic sexology on global quality of life (QOL) in females, sexual functioning, health and ability. The patients had sexual problems related to desire, genital pain, and orgasmic dysfunction. We found that holistic sexology clinically significant helped the patients to improve self-rated quality of life, self-rated sexual function, self-rated mental health with self-rated physical health often also improved. Self-esteem, ego-strength and social ability were also often improved.

43 patients with lack of sexual desire, 16 patients with genital pain including primary vulvodynia and dyspareunia, and 24 patients with orgasmic dysfunction including anorgasmia was included in the protocol, together with 33 patients with a wide range of sexual problems like vaginismus, sexual arousal syndrome, and sexual aversion disorder. The patients were between 18 and 70 years old.

The different groups underwent 20 hours of holistic sexological therapy, which started with conversational therapy, and if this did not help was complemented with bodywork, and if this did not help, complemented with genital physiotherapy as modum Hippocrates (vaginal acupressure). All dimensions were improved 15-40% (0.75 to 2.0 steps) as measured on a five point Likert Scale with the validated questionnaires QOL1 and QOL5, complemented with questions on sexual, social and working ability and ego-strength.

The global simultaneous improvement of all dimensions related to health, quality of life and ability strongly indicated that the holistic sexological treatment induced not only sexual healing, but also Antonovsky-salutogenesis (existential healing).

Introduction

In sexology there are several concerns involving the female, such as lack of sexual desire, genital pain including dyspareunia and orgasmic dysfunction including anorgasmia (1). 56.6% of Danish women about 30 years old doubt that they are sexually attractive and only 27.4% of Danish women feel satisfied sexually (2), indicating that in spite of much more sexual freedom in that country, there is still much that could be better in the sexological area.

Classical holistic medicine goes all the way back to Hippocrates and his students (3). According to “Corpus Hippocraticum” (3) these early physicians cured psychosexual developmental problems with a combination of conversational therapy, bodywork and when necessary also genital physiotherapy today often called “physical therapy for the pelvic floor” (4). The later treatment has been used today to a cure many female health problems including sexual dysfunctions, with about 50 RCTs to support its efficiency, although “the sexological examination” is recommended by Bø et al. if the treatment of sexual dysfunctions with physiotherapy alone fails (4).

During the last ten years our international research team has made a number of theoretical and clinical sexological studies (5-16), including some studies complemented with genital physiotherapy (17,18) and clinical studies in the effect of holistic therapy complemented with bodywork in general (19-22). For ethical and political reasons we have not used sexual stimulation (the sexological examination) (23-29) in our studies, but we evaluated the patients of a sexologist using a similar method in Denmark for anorgasmic women (30).

There seem to be an emerging agreement about sexological researchers that sexual dysfunction often needs more than psychotherapy. A review concluded that manual sexology is superior to psychotherapy (31). We found that holistic sexology combining psychotherapy and bodywork could help 42% of patients, who experienced sexual dysfunction (16) and the ratio of patients helped went up to 56%, if genital physiotherapy ad modum Hippocrates was also given (18). If direct sexual stimulation was used, 93% of the patients were healed (30).

A simple way to understand the increased effect with the more provocative therapeutic tools is to acknowledge Wilhelm Reich (1897-1957) and his brilliant insight, that the more directly the patients emotional resistance is addressed in therapy, the more efficient the therapy (32-34). Working directly on the genitals are provoking much more resistance than just talking and massaging the body; direct sexual stimulation is likely to be the most provocative procedure at all in the sexological field, going straight to the patients most intimate problems. From this perspective it is not at all surprising that vaginal physiotherapy and manual sexology is highly efficient in treating sexual dysfunctions.

In this chapter we test a hypothesis that holistic sexology induce Antonovsky salutogenesis and thus improving not only sexual functioning, but also physical and mental health including quality of life in general.

Theory behind our study

The psychoanalytical and psychodynamic theories by Freud, Jung and Reich are the basis of modern sexological treatment with conversational therapy (33,35,36). Sexological research has pointed towards the musculature of the circumvaginal/pelvic floor musculature (37-40) as important for many different sexual problems. Modern vaginal physiotherapy for sexual dysfunctions concentrate often on the bulbospongiosus, ischiocavernosus and the most medical fibres for the levator ani muscles as stated in a textbook (4, page 310) with the following statement: “All these findings have interesting implications for physiotherapists giving pelvic floor re-education treatments; it could be that anorgasmic women would be helped by improving the strength of their pelvic floor muscles.” The lack of effect of conversational therapy alone has meant that vaginal massage and similar techniques are

becoming more and more used by educated and modern female patients that insist on having a normal sex-life: “Increasingly physiotherapists are being asked to treat patients... complaining of dyspareunia” (4, page 312). “Physiotherapists are finding that they are able to treat many such patients very successfully using a combination of “tender loving care”, listening, counselling, education, ultrasound to soften scar tissues and the teaching of self-massage and pelvic floor exercises. No scientific evaluation of these techniques has so far been undertaken, but the gratitude of patients and their partners is significant” (4, page 312). Confrontation of the genitals is often making miracles for the patients in this area, and Polden and Mantle found that techniques like “guidance to self-examination using a mirror is often all that is needed” (4, page 312).

So sexual problems seems often to be caused by emotional problems associated with the genitals and as soon as they are solved, the patient’s level of sexual ability is often normalised. The basic method of holistic sexological therapy is therefore to work with the patient’s resistance (32-34) until all negative feelings and emotions connected to gender, sexuality and sexual organs are integrated and the patient is sexually and existentially healed.

Psychodynamically the sexually dysfunctional patients very often have strong unresolved Oedipus complexes (41) and a pronounced level of sexual masochism (34). During the process of sexual healing the patient will often have sexual transference of masochistic quality that gradually transforms into sadism, before the patient is finally healed. The therapist is well advised to take all possible precautions as the patient’s often-unconscious, sexual sadism can take any form. If the issue of sexual sadism are addressed in the therapy, before it actually appears, many problems can be avoided. Sexual sadism might be too difficult for the patient to contain, forcing her to discontinue the therapy, if this is not done elegantly.

Our experience

We present retrospective, clinical results of holistic sexology on sexual functioning, physical and mental health and quality of life of more than 100 self-referred patients treated in the period from 2003-2005 at the Research Clinic for Holistic Medicine in Copenhagen. All patients presented, according to their medical record, with a sexual problem that clinically judged by the physician, who treated them related not to a physical problem like an infection, but to a psychosomatic problem. At the evaluation in our clinic the problem was hypothesised (in accordance with psychodynamic theory) to relate to a disturbance of their childhood psychosexual development.

The therapy was a combination of psychodynamically oriented clinical holistic short-term therapy and holistic sexology, given in such a way that problems that could be solved with conversational therapy alone were solved this way; then bodywork was added, and if the patients were not cured then vaginal physiotherapy added, in a project where the classical method of Hippocratic Pelvic Massage (also called “vaginal acupressure” or “genital physiotherapy” (4)) was used. Direct sexual stimulation and the “sexological examination” (21-23) were not used in this study.

The fundamental therapeutic work was character analysis (3,33,34) and self-exploration in accordance with the life-mission theory (42-49). The bodywork was inspired by

Hippocrates, Reich, Lowen and Rosen (3,32-34,50,51). The patients were given 20 sessions (mean) during one year.

All patients were measured before and after the intervention with the validated questionnaires QOL1 and QOL5 (52) complemented with four questions on social, sexual and working ability and ego-strength (the battery of questions was all together called QOL10) (53). All data were collected using a five-point Likert Scale, which seems to be most efficient and reliable for psychometric testing (54).

The staff was holistic therapists from the Nordic School of Holistic Medicine under supervision in order to understand and use the healing methods of Hippocrates (see (55-61). The patients were diagnosed by a physician using a list of diagnoses and comparing these to the symptoms, which the patients described. The patient's global, self-assessed sexual ability was also measured as guidance for the therapist giving the diagnosis. Only chronic patients, who had had their problem for more than one year were included in the study.

43 patients entered the protocol with problems related to sexual desire, 16 patients had genital pain including primary vulvodynia and dyspareunia and 24 patients had orgasmic dysfunction including anorgasmia (see table 1). 33 patients had a wide range of other sexual problems like vaginismus, nymphomania, sexual aversion disorder, chronic arousal syndrome etc. As there were few of each type of patients these were analysed statistically as one group.

We found that patients with problems related to sexual desire responded well to holistic sexology. The group increased 0.64 steps of four theoretically possible steps on the Likert scale, which is a remarkably large, significant improvement ($p=0.01$). This group also significantly improved their physical and mental health and global quality of life (0.37, 1.23 and 1.12 step respectively). The contemporary improvement both health, quality of life, and ability strongly indicates that Antonovsky-salutogenesis (62,63) – also called “existential healing” – is induced during the holistic treatment of lack of sexual desire.

We found that patients with problems related to genital pain also responded well to holistic sexological treatment; the group increased 0.94 steps of four theoretically possible steps on the Likert scale, which is a remarkably large, significant improvement ($p=0.01$). This group also significantly improved their mental health, and global quality of life (0.85 and 1.01 step respectively). The contemporary improvement both health, quality of life, and ability strongly indicates that Antonovsky-salutogenesis – also called “existential healing” – is induced during the holistic treatment of genital pain.

We found that patients with problems related to orgasmic dysfunction also responded less well to holistic sexological treatment; the group did not increase sexual ability significantly although the tendency was found and the result could be significant with more participants in the study (the increase was 0.43 step and $p=0.1$). In spite of this, this group did significantly improve their physical and mental health, and their global quality of life (0.40, 0.88 and 0.85 step respectively). The improvement both health and quality of life indicates that Antonovsky-salutogenesis is also induced during the holistic treatment of orgasmic dysfunction; but more modest compared to the two groups described above.

For the last group of patients with miscellaneous sexual problems we found that this group responded well to holistic sexological treatment; the group increased its sexual ability significantly 0.79 step ($p=0.03$). This group did not significantly improve physical health, but mental health, and global quality of life was significantly improved (0.92 and 1.03 step respectively, with $p=0.01$ and 0.01).

The improvement of sexual ability, health and quality of life indicates that Antonovsky-salutogenesis is also induced during the holistic treatment of this group. Self-rated self-esteem, ego-strength and social ability was also measured and the patients state where often improved in these important dimensions also (see table 1). We did not find any adverse effects and no serious negative events like suicide attempts, reactive psychosis or mental hospitalisation during this study.

Ethical aspects

The most important ethical safeguards that were in place to protect the participants and therapist were the following:

- Full and complete written and oral information, including graphic illustration of the content of the therapy.
- Time to reflect about participation from informational session to the practical work.
- Everything was done under supervision; the therapists had individual supervision and they participated in a Balint group.
- The therapy followed the ethical guidelines of International Society for Holistic Health (ISHH) for holistic practitioners (64).
- Careful follow up with questionnaires about adverse effects and therapeutic outcome (qualitative and quantitative assessment and evaluation of the therapy).
- The research team has evaluated the process that is in place in the treatment organization to assure that the treatment was done according the described methods and ISHH (International Society for Holistic Health) ethical standards.

Manual sexological therapy must be performed according to the highest ethical standards (17,18). The holistic sexological procedures are derived from the holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts) and close intimacy without any sexual involvement. In psychology, psychiatry and existential psychotherapy touch is often allowed, but a sufficient distance between therapist and client must always be kept, all clothes kept on and it is even recommended, that the first name is not taken into use to keep the relationship as formal and correct as possible. The reason for this distance is to create a safety zone that removes the danger of psychotherapy leading to sexual involvement.

The female patients in holistic existential therapy and holistic sexology with life-long anorgasmia often find their situation pretty hopeless; many of them have been dysfunctional and incurable for many years or they suffer from conditions for which there has been no efficient biomedical or psychotherapeutically cure. They suffer from a condition that is a serious burden to their marital life, if they have a husband or often the problem makes them unable to find or keep a partner (65). Often the problem of anorgasmia is caused by traumas from earlier sexual abuse, which needs more effective and direct tools for the induction of healing (salutogenesis).

Table 1. The impact on health quality of life and ability of holistic sexology on patients with problems related to desire, genital pain, and orgasmic dysfunction. Scores are mean scores on the 5-step Likert scale. N the number of participants in the study presenting this problem. (*: improvement is significant, p=0.05; **: improvement is significant p=0.01)

		Physical health (self-rated)				Mental health (self-rated)				Self-esteem (self-rated)				Relation to friends (self-rated)			
		Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p
Desire	Score	2.7	2.33	0.37	.019	3.65	2.42	1.23	.000	3.28	2.41	0.87	.000	2.61	2.18	0.43	.011
	N	43	33	10	*	43	33	10	**	43	34	9	**	43	34	9	**
Genital pain	Score	3.0	2.4	0.6	.096	3.25	2.4	0.85	.054	3.19	2.2	0.99	.032	2.0	1.5	0.5	.269
	N	16	10	6		16	10	6	*	16	10	6	*	16	10	6	
Orgasmic dysfunction	Score	2.75	2.35	0.4	.016	3.17	2.29	0.88	.000	3.04	2.39	0.65	.006	2.0	1.89	0.11	.816
	N	24	17	7	*	24	17	7	**	24	18	6	**	24	18	6	
Other sexual problems	Score	2.76	2.21	0.55	.110	3.55	2.63	0.92	.002	3.24	2.36	0.88	.001	2.61	2.04	0.57	.012
	N	33	24	9		33	24	9	**	33	24	9	**	33	24	9	*

		Relation to partner (self-rated)				Ego strength (self-rated)				Sexual ability (self-rated)			
		Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p
Desire	Score	5.0	3.88	1.12	.016	3.36	2.5	0.86	.001	3.35	2.71	0.64	.014
	N	43	34	9	*	42	34	8	**	43	34	9	*
Genital pain	Score	4.3	2.9	1.4	.146	3.31	1.9	1.41	.011	3.94	3	0.94	.004
	N	16	10	6		16	10	6	*	16	10	6	**
Orgasmic dysfunction	Score	4.0	3.11	0.89	.101	3.0	2.44	0.56	.083	3.21	2.78	0.43	.110
	N	24	18	6		24	18	6		24	18	6	
Other sexual problems	Score	4.72	3.46	1.26	.083	3.39	2.29	1.1	.002	3.46	2.67	0.79	.029
	N	32	24	8		33	24	9	**	33	24	9	*

		Social ability (self-rated)				Working ability (self-rated)				Quality of life (QOL1) (self-rated)			
		Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p
Desire	Score	2.79	2.18	0.61	.002	3.09	2.53	0.56	.025	3.44	2.32	1.12	.000
	N	43	34	9	**	43	34	9	*	43	34	9	**
Genital pain	Score	2.63	1.8	0.83	.025	3.38	2.4	0.98	.037	3.31	2.3	1.01	.029
	N	16	10	6	*	16	10	6	*	16	10	6	*
Orgasmic dysfunction	Score	2.42	2.17	0.25	.381	3.0	2.67	0.33	.427	3.46	2.61	0.85	.000
	N	24	18	6		24	18	6		24	18	6	**
Other sexual problems	Score	3.06	2.29	0.77	.001	3.06	2.46	0.6	.134	3.36	2.33	1.03	.001
	N	33	24	9	**	33	24	9		33	24	9	**

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The primary purpose of the holistic existential therapy is to improve quality of life, secondary to improve health and ability. The severe conditions of the patients and the chronicity is what ethically justify the much more direct, intimate and intense method of holistic manual sexological therapy, which integrates many different therapeutic elements and works on many levels of the patient's body, mind, existence and personality at the same time. Holistic sexology is holistic existential therapy taken into the domain of sexology. The general ethical rule is that everything that does not harm and in the end will help the patient is allowed ("first, do no harm"), but we understand that this procedure is not accepted in many other countries due to sexual taboo and legal regulations.

It is though interesting that the sexological techniques have been used for centuries by physicians and for decades in Denmark also by alternative therapists outside the medical profession (17,18). An important aspect of the therapy is that the physician must be creative and in practice invent a new treatment for every patient. To use sexological techniques involving direct genital contact, the holistic sexologist must be able to control not only his/her behaviour and most strictly avoid the danger of acting out the therapeutic session turning into mutual, sexual activity. The necessary level of mastery of this art can only be obtained through training, supervision and a third person present. The role of the sexologist is parentally accepting, generous and supporting, loving and therapeutic.

In this chapter we studied about 100 female patients with often-lifelong sexual problems received holistic sexological treatment and one in two of the patients solved their problem (16,18), but more importantly their whole life seemed to improve due to salutogenesis, or existential healing.

Discussion

Orgasmic dysfunction was the only sexual problem that holistic sexology did not significantly improve, in spite of the patients becoming better physically, mentally, and existentially. It might be that treating anorgasmia takes more than 20 sessions; it is also very likely that the larger sexological tools like direct sexual stimulation and the sexological examination (23-29) must be used to cure these patients, that seems to be more blocked and "neurotic" than the other groups of patients.

It is important to notice that sexological therapy always has been holistic; the development of holistic sexology and the manual sexological tools has seemingly improved the efficacy of the sexological treatment, but from the very beginning sexological treatment has been able to help at least one in two of the patients with problems related to desire, genital pain and orgasmic dysfunction, as the statistics of Masters and Johnson showed already in the 1960s (65).

The primary reason for the improvement of sexological therapy's impact on general health, quality of life, and ability seems to be the implementation of a better understanding of the process of salutogenesis, or existential healing (62,63). The data presented here seems to support this hypothesis of "applied salutogenesis".

All in all holistic sexology seems efficient for many types of sexual dysfunctions and genital pain. Not only sexuality, but also mental health and quality of life are also improved and often physical health also. This is a strong indication that holistic sexology can induce

existential healing, or Antonovsky-salutogenesis. 20 sessions of therapy might be too little to help the female patients with the most severe sexual problems like anorgasmia.

Holistic sexology does not have any known side effects, and seems to be a fast and efficient way to help several kinds of sexually dysfunctional female patients.

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SEX IS NOT A SIN
TANTRA FOR HEALTHY SEXUALITY
MEENA NANDA

Effect of vaginal acupressure (hippocratic pelvic massage)

We conducted a pilot study of 20 female patients with sexual problems, who received vaginal acupressure (VA) with a quantitatively and qualitatively evaluation. 50% (10 of 20) experienced to have their problem solved (NNT=2 for the outcome: “cured” (vs. “not cured”)) and none reported setbacks. 80% (16 of 20) rated the treatment of high quality and 80% rated it valuable (16 of 20) (NNT=1 for the outcome: helped (vs. “not helped”)).

Most females reported their problems to be less serious and their general quality of life improved after the treatment. Only 17% (3 of 18) reported minor or temporary side effects and no significant side effects were found (NNH>18). VA was found statistically and clinically significant ($p<0.05$, improvement more than 0.5 step on a five point Likert scale) to help patients with chronic genital pains, pain or discomfort during sexual intercourse, lack of desire or orgasm, and subjective sexual insufficiency, and all patients taken as one group (about one step up a five point Likert scale).

Self-evaluated physical and mental health was significantly improved for the total group, the relationship with partner, the subjective sexual ability and the quality of life measured with QOL1 and QOL5 questionnaires. VA or Hippocratic pelvic massage is technically a simple procedure corresponding to the explorative phase of the standard pelvic examination, supplemented with the patient’s report on the feelings provoked followed by processing and integration of these feelings, but ethical aspects are complicated.

Acupressure through the vagina/pelvic massage must be done according to the highest ethical standard with great care, after content and obtaining the necessary trust of the patient within the framework of the local laws. It must be followed by conversational therapy and further holistic existential processing.

Introduction

Hippocrates (460-377 BCE), the “father of medicine” and the physicians at that time were aware of female sexual disease and his treatments included different physical procedures focused on the female pelvis, like massaging the pelvis (1). For various reasons these

treatments were later abandoned and some authors even found it a form of abuse by a medical profession with insufficient ethics (2). In holistic medicine the physician and his patients are almost always very “close” and ethics a subject of utmost importance. The practice of pelvic massage might even have been the cause and the need for medical ethics and the ability to make this procedure might be the very reason, why Hippocrates invented his strict medical ethics in the first place (3).

The technique of vaginal acupressure (VA) has been reviewed, developed and tested with a number of patients at the Research Clinic for Holistic Medicine in Copenhagen (3). The purpose of this chapter is to evaluate the procedure on a larger number of patients and investigate the effects on their quality of life.

Acupressure through the vagina

Many women have problems related to their pelvis and its organs, dominated by sufferings of the sexual organs, problems of the urinary tract, the locomotor system, and the intestines (4). Another large group of patients have “non-anatomic” pelvic pains and discomforts of presumably psychosomatic nature, very difficult to treat with biomedicine, but seems to react better to psychosomatic treatments (5,6). The problems are from a holistic medical perspective often caused by unsolved emotional problems, which have been repressed into the pelvis and its organs (repressed memory or body memory). The emotional problems are related to negative beliefs about self, gender, body, organs and sexuality.

In this chapter we discuss 20 females treated with acupressure through the vagina at the Research Clinic for Holistic Medicine in Copenhagen. All patients presented with some problem(s) related to female sexuality. The study tested the hypothesis that holistic sexology with this procedure can heal old wounds on body and soul in order to improve the sexual ability, satisfaction and quality of life in general. The healing process has as in all other holistic therapy three obligatory steps, which we sum with the words: feel, understand, and let go (7-9).

First the emotions have to be felt again: we call this phase “putting feelings onto the body”. Then the patient has to find words, verbalize the emotions and understand where the problems are coming from: we call this “putting words on the feelings”. Finally the person healing have to let go of the negative attitudes and decisions that was made, when the trauma was caused: we call this “putting consciousness in the words”.

In the clinical work we used the therapeutic staircase, which gave us the best insurance that we do not use a more invasive and potentially dangerous technique than necessary (10), or as Hippocrates said: "Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things — to help, or at least to do no harm." The Greek "First, do no harm" became "Primum non nocere" in Latin, a translation of the original perhaps, but some sources attribute "Primum non nocere" to the Roman physician, Claudius Galenus of Pergamum (131-201 AD), better known in English as Galen.

The procedure of acupressure through the vagina always builds on earlier sessions of acceptance through touch, which again come after sessions of emotional healing, trust, holding and to begin with always “love and care” for the patient.

This knowledge of healing life – improving health, quality of life and ability in one integrated movement - is well known and described in a number of books from the medical sciences cradle on the island of Cos around 300 BCE, known as *Corpus Hippocraticum*. Hippocrates was held to be the best physician of his time and father of the first scientific system of holistic healing. It is interesting that massaging the pelvis through its openings was an acknowledged method in ancient Greece (1) and was in normal use throughout Europe for centuries (2). This necessitated the very stringent medical ethics that was founded precisely by Hippocrates, probably as mentioned above with the purpose that he himself and his many pupils could give this kind of treatments.

Massage of the pelvic structures of a female through the vagina and anus could among other things heal disturbances in the female energy system, known as a disease called “hysteria”, from the Greek word for uterus, hysteria. The treatment was in use in most of the western world until the industrial revolution, where it was condemned as pornographic and hence no longer an acceptable medical treatment.

Today after the sexual revolution in the 1960s and 1970s some therapists again work through the vagina and anus with this kind of therapy, either by using their hand to cure sexual and other problems (10), or by using a vibrant penis substitute (a “dildo”) to cure incontinence (11) or orgasmic problems (12).

The Danish physiotherapist Birgitte Bonde reported that one to six sessions with the vibrator can help many incontinent women, who are not sufficiently helped by the standard program of training of the pelvic floor (11). The rationale for the use of the vibrator is that the woman cannot get in contact with their own pelvis, as they “cannot find their pelvic floor”, presumably because they have completely eradicated some of the pelvic structures from their inner description of their own body.

It is important to understand or realize that the procedure of acupressure through the vagina is the same exploration part of the standard pelvic examination by the physician or gynaecologist, but in acupressure done so slowly that the woman can feel the emotions held by the different tissues contacted by the finger of the physician (13).

Our experience

Twenty female patients received vaginal acupressure (VA) treatment for different sexual problems: chronic pain in the genitals (vulvodynia), pain or discomfort during sexual intercourse, problems with sexual desire, orgasmic malfunctioning, and other sexual inadequacy often combined with low self esteem and mental problems related to gender and sexuality.

It is important to notice that we introduced a slow pelvic examination with a therapeutic element, relevant for a wide range of psychosomatic disturbances related to gender and sexuality, from infertility to gynaecological and sexual psychosomatic problems and the long-term consequences of child sexual abuse (13).

On one hand this opens up for a clinical practice with many beneficial and healing qualities for the patient, because it allows a much closer and more intimate relationship between the patient and the physician that has been the traditional practice, but on the other hand this procedure has several disadvantages.

In many cultures this cannot be practiced due to cultural or religious reasons and the sexual taboo being so strong, that the female will experience the process as overwhelming or even insulting. In the United States it might be practically impossible to follow our recommendation in many cases, because of the time consumption, economics and reimbursement issues of this culture and the heavy “malpractice culture” in that country.

The most difficult problem of this procedure seems to be that it makes it very difficult to be sure that the procedure and all the involved steps are always necessary and rational. This procedure and the cultural issues involved means that it has a high potential for malpractice, but this can be minimized by the following steps: 1) Before the procedure is done, the patient must read about it with at least one case study to illustrate, to fully understand the emotional and existential implications of the procedure, so she has time to contemplate and make her decision of whether to accept or not; 2) The procedure is also orally presented by the physician to the patient before she signs the contract; 3) The physician must be in supervision to discuss the problems if any about borders, intimacy, emotional and sexual issues. Close supervision and full inter-collegial openness is the best prevention of malpractice, as malpractice often occur with physicians without a network and without openness about what is going on in their clinic (13) and 4) a third person present at the examination.

The participants completed the QOL5 and QOL1 questionnaires (14), before and after treatment. After the treatment they were interviewed about the side effects of the treatment, their experience of the treatment and the experienced quality and value of the treatment (see the questionnaire for the semi structured interview in appendix 1). The statistical method for estimating the level of significance was paired t-test in the SPSS statistical program. Informed consent was given before the procedure and the interview.

The procedure was performed by a male physician and a female nurse present, except in a few cases where this was not possible.

18 out of 20 patients participated in the study. Of these six suffered from genital chronic pain or discomfort, 15 suffered from problems with sexual desire or orgasmic malfunctioning and 17 also had other sexual inadequacies (see table 1).

Ten patients felt they were helped by the VA treatment, while six patients did not feel any change in their symptoms. None of the patients felt any setbacks. Success rate evaluated on intention to treat basis was 50% (10 of 20). The duration of the treatment was an average of eight weeks and four sessions, once every fortnight.

Most patients rated their problem as serious before the treatment, and neither serious nor unserious after the treatment; the average improvement here was one step of a five point Likert scale independent of suffering. This is a positive and clinically significant improvement, as experienced by the patients. Most patients would choose the treatment again, if they needed it. Most patients had good expectations for their future sexlife after the treatment.

Most patients rated the quality of the treatment to be very high (10 cases), or high (6 cases), and two rated it as average. Most patients rated the value of the treatment to be very high (13 cases) or high (3 cases), while one rated the value low and one as very low. 80% (16 of 20 evaluated on intention to treat basis) of the patients found the treatment of high quality, and 80% (16 of 20 evaluated on intention to treat basis) of the patients found it valuable. Most patients had an understanding and supporting reaction from their surroundings (family, friends and partner), if they shared the information of receiving the treatment.

Table 1. The therapeutic effect of vaginal acupressure using QOL5+QOL1 before and after the VA treatment, and questions on quality, value and efficiency of the treatment after VA treatment. Please see appendix for the exact phrasing of the questions

Question Group	2 Mean (How long did the patient have the problem/ illness?) (Years)	3 Mean (How long did the VA treatment last?) (Weeks with one VA treatment every second week)	4 Mean (Was there an alternative medical treatment?) 1 Yes, 2 No	5 Mean (Has alternative treatment been tried?) 1 Yes, 2 No	6 Mean (How serious was the problems before the treatment?) Very serious (5) to not serious at all (1)	7 Mean (How serious was the problem to the patient after the treatment?) Very serious (5) to not serious at all (1)	Delta (7-6) Mean (p-value)
1 Chronic pain (N=2)	3.00	3.00	1.50	1.00	4.50	4.50	0.00 (0.50)
2 Pain/discomfort during sexual intercourse (N=6)	11.17	2.83	1.67	1.50	4.00	3.00	-1.00 (0.09)
3 Problems with sexual desire (N=12)	7.38	9.25	1.83	1.67	3.83	3.17	-0.66 (0.136)
4 Orgasmic dysfunction (N=12)	7.96	9.50	1.67	1.59	3.83	3.17	-0.66 (0.071)
5 Self-confidence/psychological problems related to gender and sexuality (N=17)	9.15	8.53	1.82	1.65	3.81	3.00	-0.81 (0.022)
6 Other subjects concerning sexual inadequacy (N=5)	9.40	13.80	1.40	1.60	3.60	2.20	-1.40 (0.005)
7 Other subjects (N=4)	13.25	5.25	1.50	1.50	4.25	3.00	-1.25 (0.80)
ALL (N=18)	8.92	8.11	1.78	1.61	3.82	3.06	-0.76 (0.023)
GroupA (1+2) Pain or discomfort (N=6)	11.17	2.83	1.67	1.50	4.00	3.00	-1.00 (0.089)
GroupB (3+4) Lack of desire or orgasm (N=15)	6.97	8.87	1.73	1.60	3.80	3.13	-0.67 (0.067)
GroupC (5+6) Subjective sexual inadequacy (N=17)	9.15	8.53	1.82	1.65	3.81	3.00	-0.81 (0.022)

Table 1. (Continued)

Groups/Question	11 Mean (Would you choose this treatment again if needed?) 1 Yes, 2 No	12 Mean How do you expect your sexuality to evolve in the future? Very good (1) to very bad (5)	13 Mean (Could your problems have been solved in any other way?) Yes (1), Maybe (2), No (3)	14 Mean (How would you grade the quality of the treatment?) Very high (1) to very low (5)	15 Mean (How would you grade the value of the treatment?) Very high (1) to very low (5)
1 (N=2)	1.00	2.50	2.50	2.00	3.00
2 (N=6)	1.17	1.67	2.67	1.50	1.83
3 (N=12)	1.00	1.58	2.58	1.67	1.75
4 (N=12)	1.00	1.58	2.58	1.59	1.75
5 (N=17)	1.06	1.53	2.59	1.59	1.65
6 (N=5)	1.00	1.20	2.40	1.40	1.80
7 (N=4)	1.00	1.75	2.75	2.00	2.00
ALL (N=18)	1.06	1.50	2.61	1.56	1.61
GroupA (1+2) (N=6)	1.67	1.67	2.67	1.50	1.83
GroupB (3+4) (N=15)	1.00	1.53	2.52	1.60	1.67
GroupC (5+6) (N=17)	1.06	1.53	2.59	1.59	1.65

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Table 2. Clinical Effect of Vaginal Acupressure. Subjective physical and mental health, quality of relationship with partner, subjective sexual ability, and QOL (quality of life) before and after VA treatment

Groups/ Question	QOL5-1 _{before} Subjective physical health Very good (1) to very bad (5) Mean	QOL5-1 _{after} Subjective physical health Very good (1) to very bad (5) Mean	Delta QOL5-1 Mean (P-value)	QOL5-2 _{before} Subjective mental health Very good (1) to very bad (5) Mean	QOL5-2 _{after} Subjective mental health Very good (1) to very bad (5) Mean	Delta QOL5-2 Mean (P-value)	QOL5-5 _{before} Relationship with partner Very good (1) to very bad (5) Mean	QOL5-5 _{after} Relationship with partner Very good (1) to very bad (5) Mean	Delta QOL5-5 Mean (P-value)
1 (N=2)	5.00	4.50	-0.50 (0.50)	3.00 (0.00)	3.50 (0.71)	-0.50 (0.50)	3.50 (0.00)	3.42 (0.12)	-0.08 (0.50)
2 (N=6)	3.17	2.50	-0.67 (0.102)	3.50	2.83	-0.67 (0.328)	3.67	2.97	-0.70 (0.058)
3 (N=12)	3.00	2.41	-0.58 (0.012)	3.17	2.58	-0.58 (0.152)	3.47	2.71	-0.76 (0.011)
4 (N=12)	3.17	2.41	-0.75 (0.002)	3.17	2.75	-0.42 (0.241)	3.42	2.94	-0.47 (0.071)
5 (N=17)	2.71	2.29	-0.41 (0.069)	3.35	2.47	-0.88 (0.011)	3.44	2.68	-0.76 (0.002)
6 (N=5)	2.60	2.00	-0.60 (0.070)	3.00	2.60	-0.40 (0.477)	3.23	2.90	-0.33 (0.408)
7 (N=4)	3.00	2.75	-0.25 (0.391)	3.00	2.50	-0.50 (0.495)	3.13	2.42	-0.71 (0.276)
ALL (N=18)	2.83	2.38	-0.44 (0.042)	3.33	2.50	-0.83 (0.012)	3.44	2.72	-0.72 (0.003)
GroupA (1+2) (N=6)	3.17	2.50	-0.67 (0.102)	3.50	2.83	-0.67 (0.328)	3.67	2.97	-0.70 (0.058)
GroupB (3+4) (N=15)	3.07	2.40	-0.67 (0.001)	3.20	2.60	-0.60 (0.082)	3.41	2.81	-0.60 (0.021)
GroupC (5+6) (N=17)	2.71	2.29	-0.41 (0.069)	3.35	2.47	-0.88 (0.011)	3.44	2.68	-0.76 (0.002)

Table 2. (Continued)

Groups/Question	A _{before} Subjective sexual ability Very good (1) to very bad (5) Mean	A _{after} Subjective sexual ability Very good (1) to very bad (5) Mean	Delta A (before, after) Mean (P-value)	QOL 5 _{before} Quality of life Very good (1) to very bad (5) Mean	QOL5 _{after} Quality of life Very good (1) to very bad (5) Mean	Delta QOL5 Mean (P-value)
1 (N=2)	5.00	4.00	-1.00 (0.50)	5.00	4.50	-0.50 (0.50)
2 (N=6)	4.17	3.17	-1.00 (0.041)	4.33	3.00	-1.33 (0.010)
3 (N=12)	4.08	3.00	-1.08 (0.012)	3.70	2.83	-0.87 (0.064)
4 (N=12)	4.00	3.25	-0.75 (0.082)	3.92	3.17	-0.75 (0.069)
5 (N=17)	3.88	3.00	-0.88 (0.014)	3.76	2.76	-1.00 (0.005)
6 (N=5)	3.40	3.20	-0.20 (0.799)	3.80	3.00	-0.80 (0.099)
7 (N=4)	3.50	2.25	-1.25 (0.080)	3.25	3.00	-0.25 (0.789)
ALL (N=18)	3.94	3.00	-0.94 (0.007)	3.83	2.83	-1.00 (0.003)
GroupA (1+2) (N=6)	4.17	3.17	-1.00 (0.041)	4.33	3.00	-1.33 (0.010)
GroupB (3+4) (N=15)	4.00	3.07	-0.93 (0.021)	3.80	2.93	-0.87 (0.022)
GroupC (5+6) (N=17)	3.88	3.00	-0.88 (0.014)	3.76	2.76	-1 (0.011)

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The patients presented in the beginning of treatment a number of different symptoms categorized into the following seven subgroups:

- Chronic genital pain
- Pain/discomfort during sexual intercourse
- Problems with sexual desire
- Orgasmic malfunctioning
- Self esteem/mental problems related to gender and sexuality
- Other gender or sexual inadequacy
- Other problems: _____

Because of the limited number of respondents the patients were also grouped according to their problems in general: Group A (1+2) was the patients, who suffered from chronic genital pains or discomforts, group B (3+4) was the patients that suffered from lack of desire or orgasm, while group C (5+6) suffered from other forms of sexual problems. The following symptom groups were found to be helped statistically and clinically significant ($p < 0.05$, improvement more than 0,5 step on a five point Likert scale to the question “How serious was the problems before contra after?”):

- Group (2) “Pain/discomfort during sexual intercourse”,
- Group A (1+2) “Genital pain or discomfort”;
- Group B (3+4) “Lack of desire or orgasm”, and
- Group C (5+6) “Subjective sexual insufficiency”,
- All the patients taken as one group.

The treatment of all groups A-C had a good and remarkable effect on the specific problems (about one step up the Likert scale). Self-evaluated physical and mental health was also significantly and clinically improved for the total group of patients, also the relationship with partner, the subjective sexual ability and the quality of life measured with QOL1 and QOL5 questionnaires (see tables 1-3). It is important to notice the very large improvements in most of the dimensions.

Of the 18 patients only three (17%) reported side effects:

- Feelings of shame and guilt, a tear caused by an old scar being worked on, 4-5 days of bleeding and a little tenderness in an area known to the patient as a sore spot since childhood
- Genital soreness and a disturbed feeling in the body for 14 days
- “For some time I felt the pain I normally feel during intercourse: a soreness and an intense feeling of shame, and a strange feeling of weakness in the pelvic floor”.

All side effects were temporarily, and none could be considered harmful. Acupressure through the vagina therefore seems to be practically without side effects or at least at the same level as the standard normal gynecological examination. Below we present the experiences of the treatment and its results from nine patients that gave detailed information on question 10 in the questionnaire (see Appendix 1).

**Table 3. The clinical effect of vaginal acupuncture.
Paired sample T-test for the whole group (N=18)**

		Mean difference	SD	t	df	Sig.
Pair 1	Self evaluated physical health QOL5-1 (before,after)	0.44	0.86	2.20	17	.042
Pair 2	Self evaluated mental health QOL5-2 (before,after)	0.83	1.25	2.83	17	.012
Pair 3	Self-assessed sexual ability A (before,after)	1.00	1.24	3.43	17	.003
Pair 4	QOL 1 (before,after)	0.72	0.87	3.53	17	.003
Pair 5	QOL 5 (before,after)	0.94	1.30	3.07	17	.007
Pair 6	Improvement related to original problem Q6,Q7 (before,after))	0.76	1.25	2.52	17	.023

Female, aged 23 years, with psychological problems related to gender, sexuality and orgasmic dysfunction

The patient experienced that suppressed and unconscious material surfacing during the sessions. In therapy she got feelings like “everything is wrong”, and at the same time she saw and felt how her problem changed and brought her further towards her personal development; she fluctuated between joy and “darkness” in the sessions.

Female, aged 27 years, with psychological problems related to gender, sexuality, orgasmic dysfunction and lack of sexual desire

In the beginning of the therapy the patient found it very difficult to be touched on her body. Gradually as she progressed that became much easier. “I had problems letting him [the therapist] through my façade and let him touch me. I expected and hoped for a miracle to occur without my participation, since that would be far too embarrassing. I expressed my will to solve my problems by showing up in therapy, but I never took an active part in the process. I did not have the courage”.

Female, aged 22 years, with psychological problems related to gender, sexuality, orgasmic dysfunction and lack of sexual desire

The patient felt safe with the therapy and able to let out all the feelings surfacing during the sessions. She experienced different states of her development, like at first being very small, and later the wish to be sexual and feel desire. She went through a lot of inner resistance. Later she realized that she was full of hate and disgust, which stopped her from giving in to her vulnerability and open up to her sexuality. “I was so full of hate. My pelvis was shaking, but it felt so good and relieving. Afterwards I felt incredibly wonderful”. The patient experienced that she, due to the acceptance of her by the physician (SV), managed to accept her own gender. She went through a lot of shame, sadness, anger and feelings of forced penetration and got all the way through to a point, where she could enjoy and express her sexual desire and achieve fantastic orgasms with her partner.

Female, aged 23 years, with orgasmic dysfunction and lack of sexual desire

The patient experienced the treatment as very painful emotionally, as a result of psychological traumas caused by sexual abuse in her childhood. She also described the

relief in confronting the old pain with the support, acceptance and “love” or care of her therapist and holders. She processed a lot of shame and guilt. “I now have a more natural and accepting relation to my own sexuality. I no longer have the tensions connected to having sex with a boyfriend. I now feel the desire to have sex and I do not want to hold myself back the way I used to. Now I am able to accept male sexuality, which used to be a big problem for me. I realize that you get ill, if you do not accept your own nature”.

Female, aged 29 years, with huge discomfort, when touched directly on her genitals (primary vulvodynia)

VA was a highly painful procedure for the patient, who at first thought of her therapist as being evil. A nurse was present at the sessions to support the patient in processing her old pains of humiliation and embarrassment with her own sexuality – and as she slowly got through the old traumas during this therapy, the “genitals changed into a natural appearance. I have accepted my sexuality. It feels good to have sex with my boyfriend and the pain is gone. My labia changed shape – like withdrawing into my body like it accepted them as a part of me. The psychological and the physical part of me blended together and now I feel like a whole person”.

Female, aged 22 years, virgin with chronic pain (primary vulvodynia)

In the beginning of the therapy she thought of the treatment as barrier breaking. But as she also felt great trust in the methods and in her therapist she was able to give herself in to the process. She felt how she immediately began to blossom, and how sexuality became a natural part of her existence. After the treatment she was able to have sex with a partner and enjoy it. About three months later new personal problems hit the surface. She felt reserved and unfeeling with the problems coming back.

Female, aged 27 years with orgasmic dysfunction and lack of sexual desire

She described how VA has helped her attain great sexual liberation, the ability to feel sexual desire and to let go of all her inhibitions. She now sees herself as a sexual being. She is orgasmic functional and values sex as highly important for the quality of life.

Female, aged 27 years with psychological problems related to gender, sexuality and lack of sexual desire

She hated life and hated herself. She was never able to find love anywhere. As a result of this she became numb and let herself get sexually abused by men she did not love or desire in any way. In therapy she needed to confront her old traumatic pain. At first she found it difficult to re-establish contact with her own body and had become very emotionally controlled. Letting go of this control was connected with great fear. During sessions she felt nervous and insecure, because the physician (SV) “looked at her” and she tried to escape her emotions. But as she realized that she was completely safe, she decided to let go of her control and she opened up to the experience of shame, humiliation and the huge pain in her self-abuse. She remembered how she hated herself even as a child for growing faster than her friends and being ashamed of her breasts, which made her withdraw from the world. Gradually as she went through the process and felt the acceptance from her therapist, she also began to get in touch with her self-acceptance and get a whole new experience from the treatment: “It’s extremely difficult, but after a while I feel that it’s really wonderful, I’m not ashamed and I just let the enjoyment spread all the way from vulva to my uterus and my whole body. It created a fantastic wild feeling, a healing energy and warmth going into my body. It felt like my heart, my breasts and my throat melted and opened up. The feeling was beyond words”.

Female, aged 30 years with no contact to feelings and sexuality (anorgasmic)

In therapy she worked with the condemnations that she experienced as a child regarding her sexuality. She found it extremely difficult being on the couch and was very tense. She

was switching between the feeling of her boarders being trespassed and the pure trust in her therapist to realize that this treatment would be of great help. She got focused on how she suppressed her sexual desire. During the session she experienced a warm feeling of desire, but condemned it herself. She was hugely embarrassed and would not allow the sensation to be present. She got the insight that she actually did have a lot of sexual feelings, but had denied them mentally. All she had to do was to awaken them in order to get back in contact with her body. After a while the tensions disappeared. As the process proceeded she got deeper and deeper into her pain and the idea that other people would think of this as being morally reprehensible and scandalous. She started to feel great fear of condemnation and realized how she was always pre-occupied with doing “the right thing”. In spite of her fear she decided to let go of this need and stop holding back: “I feel the most wonderful desire...strange, I can’t explain it. I think I’m just experiencing all the desire that has been repressed during many years...It’s still hard, when I realize how excited I am, but I can’t fight it anymore...I hear myself breathing heavily and I feel the ecstatic sensations of orgasm waving through my body....I get the most wonderful feeling in my body and I am completely relaxed”.

In conclusion it seemed evident from the qualitative study of the patients that the majority felt helped by the VA treatment. Most patients found it valuable, also when the problem they originally presented had not disappeared. In general the patients were satisfied with the VA treatment.

Discussion

Acupressure through the vagina (VA) must be performed according to the highest ethical standards. The holistic sexological procedures are derived from the holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts) and close intimacy without any sexual involvement (15). In psychology, psychiatry and existential psychotherapy (16,17), touch is often allowed, but a sufficient distance between therapist and client must always be kept, all clothes kept on and it is even recommended, that the first name is not taken into use to keep the relationship as formal and correct as possible (18). The reason for this distance is to create a safety zone that removes the danger of psychotherapy leading to sexual involvement.

The patients in holistic existential therapy and holistic sexology are often chronically sick, and their situation frequently pretty hopeless, as many of them have been dysfunctional and incurable for many years or they are suffering from conditions for which there are no efficient biomedical cure. Many are also unaware of body memory or repressed memory due to earlier traumatic stress (19-21) and some only open up for their earlier sexual abuse through this examination, because the touch becomes the trigger between body and soul.

The primary purpose of the holistic existential therapy is to improve quality of life, secondary to improve health and ability. The severe conditions of the patients and the chronicity is what ethically justify the much more direct, intimate and intense method of holistic existential therapy, which integrates many different therapeutic elements and works on many levels of the patient’s existence and personality at the same time. Holistic sexology is holistic existential therapy taken into the domain of sexology. The general ethical rule is

that everything that does not harm and in the end will help the patient is allowed (“first do no harm”), but we understand that this procedure is not accepted in many other countries due to sexual taboos. It is though interesting that this or similar techniques have been used by many physicians (22-26) and in particular alternative therapists outside the medical profession (27-39). An important aspect of the therapy is that the physician must be creative and in practice invent a new treatment for every patient, as Yalom has suggested (40,41). To perform the sexological technique of acupressure through the vagina the holistic sexologist must be able to control not only his/her behaviour, but also his sexual excitement to avoid any danger of the therapeutic session turning into sexual activity. The necessary level of mastery of this art can only be obtained through training, supervision and a third person present. The role of the physician is asexual and therapeutic.

In our pilot study 20 female patients with sexual problems received acupressure through the vagina and evaluated both quantitatively and qualitatively with 50% (10 of 20) of the patients experienced that the procedure helped with their problem, 80% (16 of 20) of the patients rated the treatment as of high quality and 80% (16 of 20) rated it as valuable. Most reported their problems to be less serious and their general quality of life improved after the treatment.

Acupressure through the vagina seemed to have no serious side effects and self-evaluated physical and mental health was significantly and clinically improved for the total group of patients. These results were in accordance with other researchers findings in studies of “physical therapy for the pelvic floor” (42), which basically is vaginal acupressure without the element of psychodynamic talk therapy.

We therefore conclude that acupressure through the vagina can help many women with chronic genital pains, coital discomfort, problems with sexual desire and orgasmic malfunctioning, and other problems of female sexuality.

Acupressure through the vagina thus seems to be a safe and efficient procedure and important tool in the holistic medical toolbox. We recommend a full-scale clinical study of acupressure through the vagina. We also recommend that the patient treated with acupressure be contacted after 1-5 years, to prevent and handle any potential long-term negative effects of the treatment.

Appendix 1

Scientific examination of the effect of vaginal acupressure at the Research Clinic for Holistic Medicine, Copenhagen 2005

Patient's name _____

Date _____

Written accept of the treatment and the use of the data for scientific purpose.

I hereby accept, by my signature, to be part of the experiment of vaginal acupressure and that my data will be used for research in anonymized form. I have received the written patient

formula and the article in Danish about vaginal acupressure (from Ny medicin II (New Medicine newspaper))

Signature of the patient

Responsible for data collection: Herluf Riddersholm

Responsible for treatment: Søren Ventegodt

The following questions shall be written in words or as numbers in the questionnaire below

1) What was the problem/illness?

2) How long did the patient have the problem/illness? _____

3) For how long did the treatment last? _____

Define the problem using the possibilities below (more answers are allowed)

Chronic genital pain

Pain / Discomfort during sexual intercourse

Problems with sexual desire

Orgasmic malfunctioning

Self esteem / mental problems related to gender and sexuality

Other gender or sexual inadequacy

Other problems: _____

4) Was there an alternative medical treatment? 1 Yes, 2 No

5) Had the alternative treatment been tried? 1 Yes, 2 No

6) How serious was the problem to the patient before the treatment? Very serious (5) to not serious at all (1)? 5 4 3 2 1

7) How serious was the problem to the patient after the treatment? Very serious (5) to not serious at all (1)? 5 4 3 2 1

8) Describe the treatments. How was it to receive vaginal acupressure (or physical acceptance at the vulva/vagina?

Was there any side effects? 1 Yes, 2 No.

If yes, which occurred and for how long did they last?

10) Which problem/problems were solved through the treatment?

11) Would you choose this treatment again if needed? 1 Yes 2 No

12) How do you expect your sexuality to evolve in the future? (expectations to sexual capability and functioning)? Very good (1) to very bad (5). 1 2 3 4 5

13) Could your problems regarding /related to this treatment have been solved another way? Yes (1), Maybe (2) No (3). 1 2 3

14) How would you rate the quality of the treatment?
Very high (1) to very low (5). 1 2 3 4 5

15) How would you rate the value of the treatment?
Very high (1) to very low (5). 1 2 3 4 5

16) How was the reaction of your surroundings (family, friends, partner)?

QOL1: How would you assess the quality of your life now?

Answer: I: very high, II: high, III: neither high nor low, IV: low, V: very low

The QOL5 questionnaire for Clinical Databases:

Dear Mr/Mrs/Miss

In order to evaluate the benefits of appointments and treatments in the health services, we would like you to answer a few questions concerning your quality of life.

Please consider the questions carefully before answering. Then draw a circle around the most suitable answer.

QOL5-1. How do you consider your

physical health at the moment ?

- 1 Very good
- 2 Good
- 3 Neither good or bad
- 4 Bad
- 5 Very bad

QOL5-2. How do you consider your

mental health at the moment?

- 1 Very good
- 2 Good
- 3 Neither good or bad
- 4 Bad
- 5 Very bad

QOL5-3. How is your relationship with your **partner** at the moment?

- 1 Very good
- 2 Good
- 3 Neither good or bad
- 4 Bad
- 5 Very bad /I do not have one

QOL5-4. How are your relationships with your **friends** at the moment?

- 1 Very good
- 2 Good
- 3 Neither good or bad
- 4 Bad
- 5 Very bad

QOL5-5. How do you **feel about yourself** at the moment?

- 1 Very good
- 2 Good
- 3 Neither good or bad
- 4 Bad
- 5 Very bad

Please make certain that you have answered **all** the questions. Thank you for your help.

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QOL5 + QOL1 were applied before and after the treatment. If the QOL5 + QOL1 data before treatment was not obtained initially as intended, the patient answered it in the end twice, with both the actual and the initial values (retrospectively). In this case "retrospective" is noted in the questionnaire. Added to the QOL5+QOL1 questionnaire was also:

A) How would you rate your sexual ability these days?
Very high (1) to very low (5). 1 2 3 4 5

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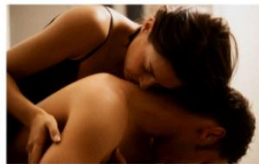
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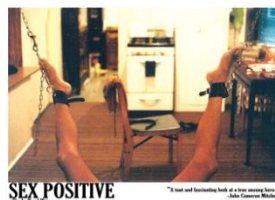
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SEX IS LIKE AIR...
IT'S NOT
IMPORTANT UNTIL
YOU'RE NOT
GETTING ANY



$$\begin{aligned} \text{let } f(x) &= \sqrt{x} \\ \lim_{x \rightarrow a} f(x) &= \frac{1}{f(a)} = \frac{1}{\sqrt{a}} f(a) \\ \lim_{x \rightarrow a} f(x) &= \frac{1}{\sqrt{a}} = \frac{1}{\sqrt{a}} f(a) \\ \lim_{x \rightarrow a} f(x) &= 0 = \frac{1}{\sqrt{a}} f(a) \\ \sqrt{x} &= \frac{1}{\sqrt{x}} f(x) \\ (\sqrt{x})^2 &= \frac{1}{\sqrt{x}} f(x)^2 \\ x &= \frac{1}{\sqrt{x}} f(x)^2 \\ \int x^2 &= f(x)^2 \end{aligned}$$



Teaching orgasm for females with chronic anorgasmia using the Betty Dodson Method

Our objective in this chapter with clinical experience of the work of Pia Struck from the European Orgasm Academy in Copenhagen was to test the Betty Dodson method of breaking the female orgasm-barrier in chronic anorgasmic women. The aim was sexual and existential healing (salutogenesis) through direct confrontation and integration of both the repressed shame, guilt and other negative feelings associated with body, genitals and sexuality, and of the repressed sexual pleasure and desire. We used a retrospective analysis of clinic data from holistic, sexological, manual therapeutic intervention, an intensive subtype of clinical holistic medicine (CHM). The patients received by Pia Struck 3x5 hours of group therapy (CHM) integrating short-term psychodynamic psychotherapy (STPP) and complementary medicine (CAM-bodywork, manual sexology similar to the “sexological examination”). The therapy used the advanced tools re-parenting, genital acceptance, acceptance through touch, and direct, sexual, clitoral stimulation. The clitoral vibrator was used. 500 female patients between 18 and 88 years old (mean of 35 years) with chronic anorgasmia (for 12 years on average) participated in the “orgasm course for anorgasmic women”. 25% of patients had never experienced an orgasm before. Results: 465 patients (93% of the patients) had an orgasm during therapy witnessed by the therapist, while 35 patients (7%) did not. Postmenopausal women were as able to get orgasm as fertile women and so were women who never had an orgasm. No patients had detectable negative side effects or adverse effects. NNT: $1.04 < \text{NNT} < 1.12$, NNH > 500. Therapeutic value: $\text{TV} = \text{NNT} / \text{NNH} > 446$. Conclusions: Holistic, sexological, manual therapy may be rational, safe, ethical and efficient.

Introduction

The female orgasm is a variable, transient peak sensation of intense pleasure, creating an altered state of consciousness, usually with an initiation accompanied by involuntary, rhythmic contractions of the pelvic striated circumvaginal musculature, often with

concomitant uterine and anal contractions, which resolves the sexually induced vasocongestion and myotonia, generally with an induction of well-being and contentment (1). Findings from surveys and clinical reports suggest that orgasm problems are the first or second most frequently reported sexual problems in women (1-4). Between 11% and 60% of adult women are suffering from lack of orgasm (2-4], depending on factors like culture and religion. On an individual level self-insight and a positive attitude towards own genitals and sexuality is important.

Female anorgasmia is a significant sexual problem; the woman who lacks orgasm often also lacks desire and joy of sexuality, has low self-esteem, often feels like a sexual failure, feels sexually wrong and ashamed of herself not being the “woman she was meant to be”. Perceptions of not being fully able to sexually satisfy her partner are normal, and quality of life is often low (3). The problem of female anorgasmia is from a psychodynamic perspective often going back to the parental lack of acceptance of the patient’s genitals, body and sexuality, often leading to intense feelings of shame and guilt, which seems to be repressed by a denial of physical and sexual needs, and accumulated in the pelvic and genital area (5,6). Sexual abuse and sexual traumas from rape and incest often cause lack of orgasm (7-11). If self-esteem is low, it is our clinical observation that there can be lack of orgasm from the simple psychological reason that the patient has not deserved such pleasure, or do not know how to get it.

It is very likely that anorgasmia is a socially inherited sexual dysfunction, but this has never been investigated scientifically. It is generally believed that anorgasmia as most other sexual dysfunctions are caused by a disturbed, psychosexual development.

Holistic medicine has cared about female sexual problems from its very beginning (12), using among other methods the famous method of Hippocratic pelvic massage, often called “vaginal acupressure” or “vaginal massage” in the Nordic countries (13,14).

Holistic sexological manual therapy is a new and developing field integrating efficient methods from standard medical sexology, Hippocratic medicine, and CAM (complementary and alternative medicine). There are many ways of working manually with the female sexual dysfunctions in the sexological clinic; from simple therapeutic touch, and acceptance through touch (6,15), to vaginal acupressure (12-14) and manipulation and stretching the pelvic muscles through the vagina.

Direct sexual stimulation in the holistic medical clinic i.e. with clitoral vibrator is a new, radical and efficient approach, where the barrier created by accumulated and repressed shame, guilt, and lack of acceptance is taken down by direct and confrontational sexological work, taking the woman all the way to orgasm in the clinical setting (16). Whenever there is a physical contact with the female genitals there is a possibility for de-charging of emotions repressed to the tissues that can be used therapeutically (17).

The method can also be used for treatment of genital and pelvic pain (6,18-20), but we have not been collecting the data to document this in the present study. We believe the method used in this study helped the patients to heal not only sexually but also existentially (21); the group setting and the therapist’s unusual willingness to use herself and her own sexuality as a tool in the therapy seemingly accelerated the process of healing (22) and caused no adverse effects.

The many qualitative interviews with the patients indicated that the intervention also often alleviated mental, social, existential and other problems (23-27), but this has not been quantitatively documented in this study.

A retrospective look at work with females

The clinical holistic therapy used short-term psychodynamic psychotherapy (STPP) in combination with the advanced holistic tools of re-parenting, genital acceptance, acceptance through touch, and direct, sexual, clitoral stimulation. The aim was sexual and existential healing (salutogenesis) through direct confrontation and integration of both the repressed shame, guilt and other negative feelings associated with body, genitals and sexuality, and of the repressed sexual pleasure and desire. The CAM-bodywork included use of clitoral vibrator.

When discussing the CAM-bodywork use of clitoral vibrators, it must be presented in a manner that communicates the scientific nature of the process. In the USA, the use of vibrators in funded research might in some States be considered unethical or even illegal. We understand that it might be difficult to get this presented research accepted in these States; but Betty Dodson PhD has been doing this work in 1973-1995 in New York City, and her method is now being used and further developed by many complementary therapists in USA and Europe. We therefore find that is it time to address this kind of work scientifically, and we hope that we will be able to present it carefully, that this quite radical work in holistic sexology can be understood and appreciated.

The clitoral vibrator chosen for the treatment was Hitachi Magic Wand, which has a very large head designed for efficient transference of vibrations to the vulva and clitoral region without causing soreness or irritation of the tissue. It can be used for an extended length of time compared to other vibrators, which is important when treating an-orgasmic women with delayed orgasmic response. From a psychodynamic perspective we find it interesting to notice that bodily pleasure seems to be even stronger repressed than emotional pain, and many layers of shame and unpleasant feelings must often be confronted before the female patient reaches the plateau of orgasm; this process needs prolonged sexual stimulation combined with therapeutic processing of emerging negative feelings and emotions, which is made possible by the specific design of this vibrator. Of course this could also be done manually (compare the historical discussion below).

The therapeutic intervention: We used the confrontational method developed by Betty Dodson. Dodson has for 40 years been known in USA as “the mother of female masturbation”, and she has spent her life teaching women to accept their own body and sexuality and allowing themselves the pleasure of genital satisfaction, alone and with a partner. Her motto is known from her many books and videos as “transforming masturbation to self-love”. To our knowledge this is the first time her method has been tested scientifically. The program has been adjusted to the Danish culture and changed according to our understanding of holistic therapy. Pia Struck has developed a program of anatomical and physiological teachings including Betty Dodson’s films, followed by intensive, existential, group therapy with very strong elements of sexual confrontation – a concept that can be boiled down to “encountering and accepting your own body and sexuality, and your genitals in structure and functioning” as well as applying all of the means of the body in order to be able to encompass higher levels of sexual excitement. An important aspect of the therapy is the therapeutic energy work (level 7 in (16)), involving the patient’s pelvic floor muscles, hip movements, making her pushing the pubic bone forward while tensing and releasing the musculature of the whole body, adding sound, complimented with different kinds of breath

work including holotropic breath work. Sexual fantasies are encouraged, while she is stimulating all her erotic zones, including breast and nipple stimulation, and clitoral, vaginal and anal stimulation. A key tool is thus the prolonged masturbation with variety and diversity. Every possible thing is done to make the female patient confront her emotional resistance related to her sexuality and to support her experience of a full body orgasm.

During therapy the therapist will give the patient a nurturing attention together with direct accepting digital contact of the vulva (level 8 in (16)). The sessions in nude is started with group psychodrama where every female patient takes the role as copulating male standing in the intercourse position of taking the female from behind; this allows for a deep emotional confrontation of the penetrating male energy, and prepare the female patient to accept being the feminine pole. This is followed by a visual confrontation of own genitals, in a room where everybody is nude, including the female therapist. In a later session the clitoral vibrator (Hitachi Magic Wand) is used by everybody present in the room to induce orgasm. In this phase the patient learns to engage her whole body in sexuality, and letting it free (freeing the Freudian “Id”, or animal aspect of the human being).

Before the intervention (3x5 hours of group therapy), written information on the intervention was given, and before giving consent to the actual therapeutic procedure, a video-introduction was given to the patients, demonstrating the procedures. After the course the patients were instructed to masturbate according to a schedule for further improvement.

The patients were not told that they were participating in a study, as the project was planned to take place in two phases; a test phase not planned for publication, in which only the patients age, number of recent, an-orgasmic years, actual presence or lack of patient’s ability to achieve orgasm on the course, and adverse effects, were registered, and a second phase now being planned, collecting much more detailed information. As we have found the already collected data of significant, scientific value we have been including them in our database for quality of life research, and presented them in the present chapter; the protocol making the use of the data possible has been approved by the local Scientific Ethical Committee of Copenhagen, Denmark. The combination of short-term psychodynamic therapy and CAM has lead to holistic, sexological, manual therapy; the method used in this study is a highly confrontational style of clinical holistic medicine, where the therapy jumps right to the rehabilitation of genital sexuality; it is known from other similar studies that this kinds of therapy is efficient in curing sexual and other health problems (28-33).

The therapist in this retrospective study was Pia Struck, who is co-chairman of the Danish Association for Sexology, who has been trained in psychodynamic psychotherapy during 1988-1991 and she had at the beginning of the study 10 years of professional experience with the treatment of sexual dysfunctions, supplemented in 2001 with personal sexological training by Betty Dodson.

We used retrospective analysis of clinic data from holistic, sexological, manual therapeutic intervention, an intensive subtype of clinical holistic medicine (CHM). The patients received 3x5 hours of group therapy (CHM) integrating short-term psychodynamic psychotherapy (STPP) and complementary medicine (CAM-bodywork, manual sexology similar to the “sexological examination” (see below)) and each paid 500 EURO for participation in the treatment program. Data were collected before, during visitation and after the last session using interviews.

500 chronically anorgasmic female patients between 18 and 88 years old (35 years in average) participated in the “orgasm course for an-orgasmic women”. On average the patients

had not had an orgasm for 12 years in average, and one in four had never experienced an orgasm before. 50 of these patients were treated individually (one-on-one), because they felt uncomfortable with participating in the group.

The visitation procedure ensured that the therapist knew when participants had histories of childhood sexual abuse and she made sure that they actually engaged in search for healing, not in an activity that allowed them to recreate their past histories of abuse. 17% of participants claimed sexual abuse in childhood; eight patients reported that they had been diagnosed as being mentally ill, six with major depression, and these six patients all reported a significant improvement following therapy. Three patients dropped out during treatment. The patients that dropped out had no adverse effects like reactive psychosis or re-traumatisation from the therapy, and no serious events like mental hospitalisation or suicide attempts happened to the patients during therapy. The patients were interviewed for about one hour after the therapy, to be sure that the patients showed no signs of psychosis and had no significant side effects from the course at this time, and no patients reported side effects or experiences likely to be caused by re-traumatisation. There were no follow up procedures, but everybody was encouraged to return for a free session if they had problems from the therapy later; no patients used this offer.

Subjective experience of having an orgasm in combination with therapist direct observation of the patient having orgasm judged from “objective orgasmic behaviour”: impression of altered state of consciousness, involuntary, rhythmic contractions of the pelvic and other musculature, vaginal and anal contractions, in combination with induction of well-being and contentment. The therapist was visually monitoring the vaginal and anal contractions. Every patient was interviewed qualitatively in the end of therapy to assess whether or not they had experienced orgasm, and the patient’s experience was compared to the therapist’s objective observations. Based on these data it was concluded if the therapy had been successful in this regard or not.

What did we find in this evaluation?

Over 110 courses held during 2001-2007 in Copenhagen and Aarhus in Denmark with 3-6 participants in each period and 500 patients in total, only one course in three had a patient that did not get orgasm (a total of 35 patient, or 7%). 93% of the patients had orgasm on during the course witnessed by the therapist. 50 patients needed individual therapy instead of group therapy; this was done successfully and gave no problems with transference and counter transference in spite of female therapist and patient being alone in the session. The problems arising from sexual transference and counter transference (34-37) can be hard to identify as such by the therapist, but are normally quite obvious for a supervisor; the therapist was in supervision during the whole period of treatment, but the supervisor did not at any time notice any problems related to sexual transference or counter transference in the therapy.

Some of the 35 patients that did not obtain orgasm reported to have an orgasm after the course, but this was not systematically registered due to limited resources for research and no follow up-procedure in this study. Many positive effects of therapy were reported, like markedly increase in self-esteem and quality of life, but these effects were not systematically investigated.

Postmenopausal women were as able to get orgasm as fertile women and so were woman who never had an orgasm, but they more often became sore from using a vibrator. The results indicated that the aetiology of orgasmic dysfunction is a disturbance of the female psychosexual development. NNT (number needed to treat): As 93% of 500 patients (95% CI: 89%-96%) were cured from anorgasmia, then NNT (number needed to treat to benefit) is calculated to be $1.04 < \text{NNT} < 1.12$.

In this study all participants were specifically interviewed about any negative side effects of the treatment, and we very carefully evaluated if there had been any signs of sexual violation (i.e. signs of re-traumatisation) or complaints over experienced sexual violation (which most often is caused by transferences (34-37), but still must be thoroughly investigated), and we found none. Brief reactive psychoses and re-traumatisation were specifically looked for but not found.

Being able to identify and address adverse reactions should include a process carefully documented with objective criteria that protects the researcher and the participant. In this CAM-study, this was simple, there were no reports at all of significant negative somatic or mental side effects, and thus no need of any objective evaluation of the side effects; the only adverse effect we found was soreness from the physical stimulation of the vulva, which always was temporary.

Patients who were severely sexually traumatised earlier in life often had some emotional difficulties, while their "old wounds" healed in the weeks after the therapy. Patients who were mentally ill (with diagnosed borderline condition or major depression, sometimes on antidepressants) were included in the study and all reported feeling mentally better after the intervention. No patients had severe, developmental crises or developed psychiatric disturbances, like depression or psychosis.

Many patients reported positive additional benefits such as increased desire and quality of life, higher self-esteem, better relation to partner etc. (see case reports at www.orgasmacademy.eu). The method of direct sexual stimulation in manual sexological therapy has no significant, negative side effects or adverse effects.

NNH (number needed to treat to harm): As none of the 500 patients reported significant side effects, in spite of extremely confrontational sexological therapy, it is safe to conclude that even the most intensive and provocative tools of the advanced toolbox of clinical holistic medicine (CHM, short-term psychodynamic psychotherapy combined with CAM/Bodywork) is safe for the patients, if used correctly. $\text{NNH} > 500$. If we include the 500 patients treated in other studies with CHM we find that $\text{NNH} > 1,000$ (28-32). Calculation of "therapeutic value" $\text{TV} = \text{NNH}/\text{NNT}$: Using the largest value of NNT, we find $\text{TV} = \text{NNH}/\text{NNT} > 500/1.12 = 446$.

Ethical aspects

The most important ethical safeguards that should be in place to protect the participants and therapist are the following:

- Full and complete information, including video demonstration of the content of the therapy.
- Time to reflect about participation from video demonstration to the practical work.

- Everything is done under supervision; the participants supervise every process in the group and supervisor carefully supervise the therapist. Supervision was done especially careful when it came to one-on-one therapy and the therapist was not naked in these sessions. One-on-one therapy was only done, because the patients did not want to be treated with other people in the room, as described above.
- The therapy follows the ethical guidelines of the International Society for Holistic Health (ISHH) for holistic practitioners.
- Careful follow up with interview about adverse effects and therapeutic outcome (qualitative assessment) and evaluation of the therapy.
- The research team has evaluated the process that is in place in the treatment organization to assure that the treatment was done according the described methods and ISHH ethical standards.

Manual sexological therapy with direct sexual stimulation must be performed according to the highest ethical standards. The holistic sexological procedures are derived from the holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts) and close intimacy without any sexual involvement (13,14). In psychology, psychiatry and existential psychotherapy touch is often allowed, but a sufficient distance between therapist and client must always be kept, all clothes kept on and it is even recommended, that the first name is not taken into use to keep the relationship as formal and correct as possible. The reason for this distance is to create a safety zone that removes the danger of psychotherapy leading to sexual involvement.

The female patients in holistic existential therapy and holistic sexology with life-long anorgasmia often find their situation pretty hopeless; many of them have been dysfunctional and incurable for many years or they suffer from conditions for which there has been no efficient biomedical or psychotherapeutically cure. They suffer from a condition that is a serious burden to their marital life, if they have a husband; often the problem makes them unable to find or keep a partner. Often the problem of anorgasmia is caused by traumas from earlier sexual abuse, which needs more effective and direct tools for the induction of healing (salutogenesis).

The primary purpose of the holistic existential therapy is to improve quality of life, secondary to improve health and ability. The severe conditions of the patients and the chronicity is what ethically justify the much more direct, intimate and intense method of holistic manual sexological therapy, which integrates many different therapeutic elements and works on many levels of the patient's body, mind, existence and personality at the same time. Holistic sexology is holistic existential therapy taken into the domain of sexology. The general ethical rule is that everything that does not harm and in the end will help the patient is allowed ("first, do no harm"), but we understand that this procedure is not accepted in many other countries due to sexual taboo and legal regulations.

It is though interesting that this or similar techniques have been used for centuries by many physicians (13,14) and in particular alternative therapists outside the medical profession (13,14). An important aspect of the therapy is that the physician must be creative and in practice invent a new treatment for every patient. To use a sexological technique involving direct sexual, clitoral stimulation the holistic sexologist must be able to control not only

his/her behaviour and most strictly avoid the danger of acting out the therapeutic session turning into mutual, sexual activity. The necessary level of mastery of this art can only be obtained through training, supervision and preferably a third person present, which is one of good reason for doing this in a group setting. Sometimes the patients are too shy to have more than the therapist present in the room; in this case the therapy can only be done one-on-one, and this has not caused problems. The role of the sexologist is parentally accepting, generous and supporting, loving and therapeutic.

The treatment included masturbation under supervision and instruction, where the client under therapist's instruction used the clitoral vibrator after initial, digital stimulation. In this, study 500 female patients with often-lifelong anorgasmia received direct sexual stimulation of the clitoris during the therapy and 93% of the patients experienced that the procedure solved their problem. The success of this study gives us one more very important tool for holistic medicine; together with the other tools of holistic manual therapy like acceptance through touch and acupressure through the vagina we now have tools for solving problems related to female sexual dysfunction. We therefore conclude that direct sexual stimulation can be a safe and efficient procedure and an important new tool in the holistic medical toolbox.

Discussion

Direct sexual stimulation of women has a long history; before the use in the sexological examination (see below) it was used in holistic medicine for millennia. In the Corpus Hippocratic, "hysteria" is described as a disease caused by the energies related to the womb, treatable with exercise and pelvic massage (12,38); Celcus and Soranus recommended in the first century AD genital massage for hysteria (39,40); Aretaeus Cappadox recommended the same in the third century AD based on Hippocrates (41); Galen (around 129-200 AD) also understood "hysteria" as caused by lack of psychosexual development (42); he carefully described, obviously based on Hippocrates, the procedure of genital massage therapy, resulting in the contractions and the release of fluid from the vagina, after which the patient was relieved of her symptoms. The great respect for Hippocrates and Galen made the procedure of genital massage a standard procedure until the end of the nineteenth century (43). Ätius of Amida (502-75) thus described in "tetrabiblion" a uterine contraction, muscle spasm of the entire body, and discharge of fluid from the vagina (44); Muschion's Gynaecia described the procedure a little differently as manual therapy of the vulva (45). Rhazes, an Arab physician described a similar procedure around 900 AD (43)]. It is not clear from most medieval sources whether the manipulation of the female genitals needed to go all the way to orgasm to be therapeutic (43), but many sources wrote that it is necessary to continue the massage treatment until the vagina discharges its fluid, indicating that the physician's massage must be sexually stimulating for the therapy to work (43) and the descriptions of universal muscle contractions mentioned above leave little doubt that the treatment was taken all the way to orgasm. It is clear that many different styles of genital massage have been used, some concentrating on raising the energy of the uterus, like Hippocrates and others like Muschion and Rhazes focusing more on the sexual stimulation of the vulva. The many historical sources leave little doubt that physicians for millennia have successfully used this kind of massage therapy to heal the female patient and free her from severe physical, mental,

existential and sexual problems. The rationale for such a therapy, that seems strange and quite mysterious for most modern physicians, is that there is a close statistical connection between sexual maturity and physical and mental health and general well-being, as recent research has documented (46-60).

Comparison with the traditional sexological examination

Reich, Hartman, Fithian, Morgan, Hoch and other researchers in sexology developed in the middle of the last century a sexological intervention they called “sexological examination” (61-68). With regard to the obvious, above mentioned, ethical problems in treating with direct sexual stimulation, we must emphasize that this “sexological examination” from the beginning included the method of direct sexual stimulation (65). The method is in contemporary use by Hartman, Fithian and many others. Hartman and Fithian noted that they do not as a part of the examination intentionally stimulate the patient to “a high level of arousal”, but “some women do become aroused, and occasionally a sex flush will be observed in the process practice of the vaginal caresses” (68).

The sexological examination involves all parts of the genitals including vagina, the labia minores and majores, and the clitoris (62-68). It is noteworthy that the tradition of sexological examination seemingly has been without ethical difficulties; the reason for this is presumably that everything in the sexological clinic is taking place after consent and obviously justified by the severity of problems of sexual dysfunction, which often completely has destroyed the patient’s sexual and marital life. Some of the obligatory steps of the sexological examination are according to Hartman and Fithian (68):

- Acquainting the female with her own body to dispel some of the feeling that the genital area is a special place forbidden for all but physicians to see.
- Searching for areas where nerve endings come together in a systematic way, suggesting that this may develop positive feelings.
- Assisting women in determining areas of perception, feeling, and awareness in their vagina. Pointing out areas in the vagina that tend to be more sensitive and responsive for many women (i.e., 12 o'clock, 4 o'clock, and 8 o'clock positions).
- Determining a woman's response and arousal patterns. Indicating to her whether or not she lubricates well and vasocongests when she does.
- Locating areas digitally that may be producing pain, discomfort, or problems with sexual arousal or intercourse—such as separation of muscle in the vaginal wall; long labia minora; scarring, which may be tender or fibrous—and to pinpoint the source of "pain" when present.
- More important than the stimulation of the clitoris in the female sexological examination is the determination of whether or not clitoral adhesions are present. This is a condition where the prepuce is stuck or adhered to the glans clitoris. For preorgasmic women, the inability of the clitoris to withdraw as part of sexual arousal may prevent particular women from full response. Even though some women are orgasmic with clitoral adhesions, freeing them usually results in easier, quicker orgasms and less discomfort due to calcified, trapped smegma.

- Identifying, where present, reasons for vaginismus, which are not only physiological but psychological.

The sexological examination was called an examination, not a treatment, presumably to make it more acceptable to the public, but it has always been as much a treatment as an examination (61-68). When we consider this, we must conclude that the method of direct sexual stimulation in itself is not remarkable or problematic; is it a traditional sexological tool for treating sexual dysfunction. What is different with the Betty Dodson method is the obligatory step of supporting the patient in going all the way to experiencing a full orgasm during the therapy.

The holistic, manual, sexological therapy used in this study was performed in the feminist tradition of nudity, expressive sexuality, genital self-exploration with mirrors, and common masturbation in a group of females with a female instructor. It also build on the 40-year long process of sexual liberation in the western societies, making it less problematic for Danish women of all ages to participate in the group and share their sexual problems. The efficient elements of the highly confrontational method for breaking the female orgasm-barrier in patients with anorgasmia seems to be re-parenting, genital self-touch, acceptance through touch, and the direct, sexual, clitoral stimulation in therapy, allowing all the difficult feelings associated to genitals, the pelvis and body, and sexually to emerge for be processed in therapy. The clitoral vibrator was used.

In the traditional sexological examination the therapist is not naked, the therapist is often male, and therapy happens without the common masturbation that seems to be an important aspect of Dodson's treatment, presumably because of the emotional resistance provoked by this radical procedure. The patients are normally not taken all the way to orgasm, although this occasionally happens, without this becoming a problem or in conflict with the ethical rules. On the other hand Betty Dodson sometimes avoids the digital stimulation of her female patients' genitals that is obligatory in the sexological examination, by using the mechanical stimulator. The specific features of masturbation and nudity that makes Betty Dodson's method spectacular and somewhat alienating, controversial and strange to normal therapists, especially if they are trained as physicians or nurses, seems to be to enhance the therapeutic resistance work; other elements like direct sexual stimulation are, in spite of their radical nature, traditional elements of the "sexological examination", and also of the Hippocratic tradition of psycho-sexual healing and salutogenesis. All this indicates that the tool of direct sexual stimulation of the patient should be accepted as a usable therapeutic tool, and added to the advanced holistic medical toolbox.

We know for sure that not too many therapists would like to masturbate naked with their patients in the future. We also know now that direct sexual stimulation is one of the most powerful tools of holistic, sexological, manual therapy, and has been so for millennia. As 11-60% of all women on the planet seems to be struggling with anorgasmia and problems related to sexual pleasure and desire often destroying their sexual life or hindering them in having a happy and successful marital life, we cannot afford to be "tight" and moral in our attitude towards this powerful, medical tool, and let the patients down that so desperately need it.

Manual sexological work taking the female patient to orgasm is creating a huge arousal in the patient, and can obviously also be sexually gratifying for the therapist, also without the therapist acting out. Sexuality is pleasurable, this is how we are made as human being, and there is nothing we as sexually normal therapists can do about it. But we can be extremely

certain that we have the training needed and the ethics needed to prevent us from acting out sexually towards our patients during the therapy. In this study we very carefully evaluated if there had been any signs of sexual violation or complains over experienced violation (which most often is caused by transferences but still must be thoroughly investigated) and we found none.

The correct indication for direct sexual stimulation needs some reflection. The Hippocratic physicians used hysteria and poor psychosexual development as sufficient indication; in our study the indication was anorgasmia. As it is well known from recent research (46-60) that psychosexual development and mental illness seems to be very closely related, as Hippocrates, Galen, Freud, Jung, Reich and many more physicians have realised.

Direct sexual stimulation can obviously be used to facilitate the sexual development of the an-orgasmic woman (often describes as caught in infantile autoerotism). The next important research question is if the much more subtle shift from immature clitoral sexuality, closely correlated to neurotism and immature psychological defences (46), to mature vaginal sexuality can also be facilitated by the tool of direct sexual stimulation? Our own findings and other studies (13,14,28-33,37,46-60) that has shown strong associations between genital maturity and a number of aspects of health, justifies such a study. From a theoretical perspective it is highly likely that the resistance work done in this kind of therapy is quite unique, and therefore of great value, when other methods fails.

It is not clear to us if there are ethical problems connected with using the diagnosis of immature sexuality as an indication for the treatment with direct sexual stimulation; obviously there have been no ethical problems with this treating on such an indication during the history of the European physicians, so it is hard to see why there should be ethical problems today, as long as the intent is to help the patient, and as long as the treatment is documented to give this help.

It must be recalled that every procedure that allows the therapist to take the patient into her resistance will be therapeutic and helpful, so the wise answer might be to let the resistance of the patient guide the choice of the proper therapeutic tools of the holistic sexological treatment as recommended by Reich, the founder of sexology (61).

Conclusion

Lack of orgasm is a very serious sexual problem for countless millions of women of our time as 11-60% or all women seem to suffer from lack of orgasm, without getting the help they need, neither from their physician, their gynaecologist, psychotherapist, or their sexologist and they often live their whole life with anorgasmia and related problems. Most surprisingly almost all women can learn to have an orgasm in holistic therapy, with 93% of female patients experiencing orgasm after only 15 hours of holistic, sexological, manual therapy using the tool of direct, sexual stimulation (16), in spite of the patient never having had an orgasm. Postmenopausal woman are just as able to get orgasm as fertile women in the therapy.

The female orgasm barrier seems to be caused primarily by the parental lack of acceptance of the girl's genitals and sexuality, and other sexual traumas leading to arrested psychosexual development. This theory seems to be in accordance with the presented results:

that it can be healed simply by giving the acceptance to body, sexuality and genitals that the patients never received, and thereby rehabilitating the lost self-acceptance. A combination of parental acceptance, acceptance through touch, and direct sexual, clitoral stimulation allowed the patients to confront and let go of the shame, guilt and other negative feelings that during the patient's upbringing had been connected to genitals and sexuality. Holistic, sexological, manual therapy is extremely efficient, and sexologists who are trained in psychodynamic psychotherapy and ethics of therapy can use the tools of direct sexual, clitoral stimulation when psychodynamic psychotherapy and less sexually confrontational bodywork cannot solve the female patients problems related to orgasm and sexual desire.

Manual sexological examination and treatment has been a practical tool in sexology for at least 50 years, and before that it was a part of the holistic medical tradition. Holistic, sexological, manual therapy is therefore likely to also be efficient with the other sexual dysfunctions like lack of sexual desire, vaginism and genital pain/vulvodynia, low sexual self-esteem, and poor psychosexual development in general, but this needs further scientific investigation.

To prevent the huge problem of female anorgasmia in the future generations we need to work on a societal and cultural level, to develop parental positive attitudes towards the child's sexuality, body and genitals. Of course this will start with the parents themselves learning to accept their own bodies and sexuality, and especially with the mother learning to have orgasms themselves, as it judged from the present findings is most likely that anorgasmia is a socially inherited, sexual dysfunction.

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Impaired self-rated ability of functioning sexually improved by psychodynamic short-term therapy complemented with bodywork

In this chapter we look at a clinical follow-up study conducted to examine the effect of clinical holistic medicine (psychodynamic short-term therapy complemented with bodywork) on patients with poor self-assessed sexual ability of functioning. We found that this problem could be solved in 41.67% of the patients ((95% CI: 27.61% - 56.7%; NNT=2,48 (1.75<NNT<3.62, p=0.05)).

The bodywork was inspired by Marion Rosen's method and helped the patient to confront painful emotions from childhood trauma and thus accelerated and deepened the therapy. The goal of therapy was the healing of the patient's whole life through Antonovsky-salutogenesis. In this process, rehabilitation of the patient's character and purpose of life is essential, and assisting the patient recover his sense of coherence (existential coherence) is the primary intent.

We conclude that clinical holistic medicine is the treatment of choice if the patient is ready to explore and assume responsibility for his existence (true self) and is willing to struggle emotionally in the therapy to reach this important goal. When the patient heals existentially, both quality of life, health and ability of functioning in general is improved in the same time.

Introduction

In some studies it has been shown that 25-50% of the western population complains about sexual issues (1). We measured sexual ability in 109 patients who entered the Research Clinic for Holistic Medicine for the years 2004-2005 (2-4) and found that 48 of these patients complained about significant sexual issues regarding their self-assessed ability of sexual function.

These patients entered a sexological study where their sexual ability could be addressed directly or (more often) indirectly through rehabilitation of their natural being and knowledge of self. The intention was healing their whole life, more precisely induction of Antonovsky salutogenesis (5,6).

A recent paper documented that this effort has generally achieved successful outcomes with patients diagnosed as having somatic, mental, existential, or sexual issues (7). In this study, we analyzed the effect that this treatment had on the patients with the most significant sexual problems.

Our experience

The patients were included in our study, if they assessed their sexual ability of functioning as impaired or very impaired before the treatment started. They received treatment with clinical holistic medicine (2-4), a kind of psychodynamic short-term therapy earlier found effective on a long range of health problems (9-13). The patients were also evaluated for sexual issues that existed along three axis: desire, orgasmic dysfunction and sexually related pain (mostly pain during intercourse, primary vulvodynia, or pelvic tension pain) (14). The body work was inspired by Marion Rosen and helped the patients to confront old emotional pain from childhood trauma repressed to the body-mind (3).

Forty-eight patients entered the study having self-assessed impaired ability of function sexually before treatment (self-assessed as being 'impaired' or 'very impaired'. Twenty patients rated their sexual functioning as adequate after treatment: (self-assessed sexual ability of functioning: very good, good, or neither good nor bad): Of those 20 patients, eight of these completely resolved the issue (rating good or very good) and twelve were improving (rating: neither good nor bad).

Eleven of the patients continued to self-assess their sexual issues as impaired after the treatment (self-assessed sexual ability of functioning: bad or very bad). The response rate of follow-up survey was 64.6%. Seventeen patients were classified as non-responders upon follow-up or withdrew during the study. After the treatment, 28 patients were either still poorly functioning sexually, or classified as non-responders upon follow-up, or withdrew from the study early.

The "rate of cure" of the treatment was $20/48 = 41.7\%$ (95%CI: 27.6% - 57.0%) (15). Number needed to treat (NNT) of clinical holistic medicine with sexually poorly functioning patients = 2.48 (1.75-3.62). Number needed to harm (NNH) is estimated from treating more than 500 patients in our clinic since year 2000 with this therapy (7,16) none of which had severe side effects or harmed themselves or other people during the therapy; NNH estimated >500. The patients healed not only their sexuality, but also their whole being because of the induction of Antonovsky-salutogenesis. Both physical and mental health, relations to self, friends, partner and ability of function socially and to work was improved, as was the patient's self-assessed quality of life. Quality of life, health and relations were measure with QOL1 and QOL5 (7,17).

Table 2 shows that 43 of the 109 patients had sexual issues related to desire, 16 patients had problems related to sexually related pain; 24 patients suffered from orgasmic dysfunction and 33 patients had other sexual problems. One patient could have more than one issue.

Interestingly, physical health, mental health, relation to self, friends and partner, ability to love, function socially, working ability [meaning ability to sustain a full time work], and self-evaluated quality of life (QOL1) (17) did also improve for many of the patients during the therapy. The general beneficial effect of the therapy is due to the induction of Antonovsky-salutogenesis (5,6).

Table 1. Patients with severe sexual problems who entered the study

	Before Treatment		After Treatment	
Low self-assessed sexual ability	48		11	
High ability to function sexually	0		20 = 41.67% (95% CI: 27.61–56.7%)	
Nonresponders or dropouts	—		17	
Low sexual ability, nonresponder or dropout	—		28	

Table 2. Summary of patients identified sexual issues

		Self-Evaluated Physical Health				Self-Evaluated Mental Health				Relation to Myself				Relation to Friends			
		Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p
Desire	Val	2.7	2.33	0.37	.019	3.65	2.42	1.23	.000	3.28	2.41	0.87	.000	2.61	2.18	0.43	.011
	N	43	33	10		43	33	10		43	34	9		43	34	9	
Pain	Val	3	2.4	0.6	NS	3.25	2.4	0.85	NS	3.19	2.2	0.99	.032	2	1.5	0.5	NS
	N	16	10	6		16	10	6		16	10	6		16	10	6	
Orgasmic dysfunction	Val	2.75	2.35	0.4	.016	3.17	2.29	0.88	.000	3.04	2.39	0.65	.006	2	1.89	0.11	NS
	N	24	17	7		24	17	7		24	18	6		24	18	6	
Other problems	Val	2.76	2.21	0.55	NS	3.55	2.63	0.92	.002	3.24	2.36	0.88	.001	2.61	2.04	NS	.012
	N	33	24	9		33	24	9		33	24	9		33	24	9	

		Relation to Your Partner				Self-Evaluated Ability to Love				Self-Evaluated Sexual Function			
		Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p
Desire	Val	5	3.88	1.12	.016		2.5	0.86	.001	3.35	2.71	0.64	.014
	N	43	34	9			42	34	8	43	34	9	
Pain	Val	4.3	2.9	1.4	NS	3.31	1.9	1.41	.011	3.94	3	0.94	.004
	N	16	10	6		16	10	6		16	10	6	
Orgasmic dysfunction	Val	4	3.11	0.89	NS	3	2.44	0.56	NS	3.21	2.78	0.43	NS
	N	24	18	6		24	18	6		24	18	6	
Other problems	Val	4.72	3.46	1.26	NS	3.39	2.29	1.1	.002	3.46	2.67	0.79	.029
	N	32	24	8		33	24	9		33	24	9	

		Self-Evaluated Social Function				Self-Evaluated Working Capacity				Self-Evaluated Quality of Life (QOL1)			
		Before	After	Δ	p	Before	After	Δ	p	Before	After	Δ	p
Desire	Val	2.79	2.18	0.61	.002	3.09	2.53	0.56	.025	3.44	2.32	1.12	.000
	N	43	34	9		43	34	9		43	34	9	
Pain	Val	2.63	1.8	0.83	.025	3.38	2.4	0.98	.037	3.31	2.3	1.01	.029
	N	16	10	6		16	10	6		16	10	6	
Orgasmic dysfunction	Val	2.42	2.17	0.25	NS	3	2.67	0.33	NS	3.46	2.61	0.85	.000
	N	24	18	6		24	18	6		24	18	6	
Other problems	Val	3.06	2.29	0.77	.001	3.06	2.46	0.6	NS	3.36	2.33	1.03	.001
	N	33	24	9		33	24	9		33	24	9	

Fifty-six percent of the clinics patients reported sexual issues, and received in average 14.8 session to a cost of 1,188.00 EURO. A later follow-up study documented the results of clinical holistic therapy were not temporary (7).

Tables 3-6 shows that when sexual ability is improved in therapy, physical health, mental health, relation self, relation to friends, relation to partner, ability of love, social ability and work ability, as well as quality of life are also radically improved. These results are highly significant.

Tables 3-6 shows that when the patient with the experience of sexual inadequacy healed his life (entered the state of salutogenesis) the sexual issues were resolved and all other dimensions of existence were improved as well.

Table 3. Patients with sexual problems who succeeded in experiencing antonovsky-salutogenesis (T-Test paired samples statistics)

		Mean	N	Std. Deviation	Std. Error Mean
Physical health	Before	2.7368	19	0.87191	-0.20003
	After	2.2105	19	0.85498	0.19615
Mental health	Before	3.7000	20	0.86450	0.19331
	After	2.1000	20	-0.85224	-0.19057
Self-esteem	Before	3.5000	20	0.76089	0.17014
	After	2.3500	20	-0.98809	0.22094
Relation to friends	Before	2.5500	20	0.99868	0.22331
	After	1.9500	20	0.88704	0.19835
Relation to partner	Before	4.2000	20	2.01573	0.45073
	After	2.6500	20	2.05900	0.46041
Ability to love	Before	3.6500	20	1.18210	0.26433
	After	2.1500	20	1.26803	0.28354
Sexual ability	Before	4.4000	20	0.50262	0.11239
	After	2.5000	20	0.68825	0.15390
Social ability	Before	3.0500	20	1.14593	0.25624
	After	2.0000	20	0.79472	0.17770
Work ability	Before	3.1053	19	0.93659	0.21487
	After	2.1579	19	1.06787	0.24499
Quality of life	Before	3.6000	20	0.99472	0.22243
	After	2.2500	20	1.01955	0.22798

Table 4. Paired samples test

	Paired Differences					t	df	Significance (Two-Tailed)
	Mean	Std. Deviation	Std. Error Mean	95% CI of Difference				
				Lower	Upper			
Physical health	0.5263	0.84119	0.19298	0.1209	0.9318	2.727	18	0.014
Mental health	1.6000	1.18766	0.26557	1.0442	2.1558	6.025	19	0.000
Self-esteem	1.1500	1.18210	0.26433	0.5968	1.7032	4.351	19	0.000
Relation to friends	0.6000	1.18766	0.26557	0.0442	1.1558	2.259	19	0.036
Relation to partner	1.5500	2.06410	0.46155	0.5840	2.5160	3.358	19	0.003
Ability to love	1.5000	1.50438	0.33639	0.7959	2.2041	4.459	19	0.000
Sexual ability	1.9000	0.85224	0.19057	1.5011	2.2989	9.970	19	0.000
Social ability	1.0500	1.31689	0.29447	0.4337	1.6663	3.566	19	0.002
Work ability	0.9474	1.22355	0.28070	0.3576	1.5371	3.375	18	0.003
Quality of life	1.3500	1.34849	0.30153	0.7189	1.9811	4.477	19	0.000

Table 5. Paired samples statistics

		Mean	N	Std. Deviation	Std. Error Mean
Relations	Before	3.4167	20	0.93580	0.20925
	After	2.3167	20	0.86839	0.19418
Ability	Before	3.5395	19	0.65226	0.14964
	After	2.1842	19	0.75389	0.17295
QOL (QOL 5)	Before	3.3509	19	0.64763	0.14858
	After	2.2456	19	0.68351	0.15681
Health-QOL-Ability (QOL 10)	Before	3.3735	18	0.59609	0.14050
	After	2.1574	18	0.58049	0.13682

Table 6. Paired samples test

	Paired Differences					t	df	Significance (Two-Tailed)
	Mean	Std. Deviation	Std. Error Mean	95% CI of Difference				
				Lower	Upper			
Relations	1.1000	0.99766	0.22308	0.6331	1.5669	4.931	19	0.000
Ability	1.3553	0.89488	0.20530	0.9239	1.7866	6.601	18	0.000
QOL (QOL 5)	1.1053	0.76419	0.17532	0.7369	1.4736	6.304	18	0.000
Health-QOL- Ability (QOL 10)	1.2160	0.65814	0.15512	0.8888	1.5433	7.839	17	0.000

Conclusion

Sexual issues are very common and a successful strategy to resolve them seems to be personal development of the sense of coherence, healing the whole being, not only of sexual life. The combination of psychodynamic therapy and bodywork seems efficient and creates fast, affordable and lasting results with no side effects. The patient must be willing to face deep existential problems and very unpleasant feelings when the old traumas are confronted and the old emotional charge re-integrated. The goal of the psychodynamic therapy is that the patients learn to know their true self. Not all patients are ready for that, so clinical holistic therapy is the therapy of choice when the patient is motivated for a deep inner exploration.

Clinical holistic medicine is our name for psychodynamic short-term therapy complemented with bodywork. The rehabilitation of character and purpose of life was essential, and assisting the patient recover his existential coherence was the primary intent of the therapy (5,6,18-21).

We found NNT=2 (cure) and NNH>500. The improvement of all patients was 60% (mean) in all measured dimensions of quality of life, physical and mental health, and ability, strongly indicating existential healing (Antonovsky salutogenesis).

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The holistic view of the adolescent's sexual development

Effective caring for adolescents hinges on trust. Establishment of trusting relationships with health care providers opens the door for discussion of sensitive issues such as, sexuality and risk-taking behaviour. Methods to gain trust on the part of the provider include: being relaxed, genuine, friendly, open, making eye contact. Additionally, being an authority not authoritarian, and understanding that development of full trust may take time. Adolescents view health care providers as an important source for information and education especially regarding healthy sexual development.

Introduction

Understanding adolescent development and the psychosocial developmental stages of adolescence is helpful and necessary for anyone working with adolescents. Adolescents undergo three stages of development: early adolescence (ages 12-14 years), middle adolescence (15-17 years), and late adolescence (18-20 years) (1). Early adolescence is characterized by concrete thinking necessitating the importance of keeping explanations short and to the point. In contrast, middle adolescence is defined by the development of abstract thinking. Risk-taking behaviour is mostly likely to occur within this age group and peer influence is significant (1). Older adolescence is the transition to adulthood. Adolescents in this age group have a clear understanding that their actions will result in consequences. Yet they still need support and encouragement to understand that they should make their own health care decisions.

Effective caring for adolescents hinges on trust. Establishment of trusting relationships with health care providers opens the door for discussion of sensitive issues such as, sexuality and risk-taking behaviour (1). Methods to gain trust on the part of the provider include: being relaxed, genuine, friendly, open, making eye contact. Additionally, being an authority not authoritarian, and understanding that development of full trust may take time (1). Adolescents view health care providers as an important source for information and education especially regarding healthy sexual development (2).

Leading causes of mortality and morbidity in adolescents continue to be mainly preventable, such as: accidents, homicide, suicide, sexually transmitted infections, teen pregnancy, eating disorders and drug abuse related consequences (3). All these factors in morbidity and mortality are directly related to risk-taking behaviours (3). The above factors were part of the development of adolescent medicine as a new subspecialty (4-6), while continuing to be an integral part of general practice. With the teenagers preventive medicine is extraordinarily important as so many problems are preventable in this age: pregnancy and contraception (7), HIV (8,9), substance use and abuse (10-12), ethics, law, sports (13), violence (14), prostitution and victimization (15). In adolescent medicine, knowledge of psychosomatics is very important as they are related to the 20-30% of the teenagers suffering from either chronic pains (16), psychiatric disturbances (17-19), eating disturbances (20-22), vulvodynia and other gynaecological problems (23-25). Many of the problems can be seen as disturbances in the teenager's psycho-social and sexual development, often with patterns going back to their childhood (26). As an example, fifty percent of both anorectic and bulimic patients reported a history of sexual abuse, while only 28% of a non-anorexic, non-bulimic control population reported similar problems (27) leading the authors to recommend that sexual issues be addressed early in the treatment of patients with eating disorders. In this article we will attempt to illustrate the need for more comprehensive and preventive approach to the adolescent in the clinical setting for a better outcome.

CASE STORY

14 year old girl referred to our clinic for evaluation of recurrent pelvic pain. She was seen in the emergency department seven days ago, where she was diagnosed with pelvic inflammatory disease. Review of the emergency department physician records showed "Sexually active teen with multiple partners, diagnosis: pelvic inflammatory disease, standard treatment regimen prescribed".. During interview in our clinic, the patient appeared depressed, shy, not making eye contact and complained of recurrent abdominal and pelvic pain for the last six years. Once a rapport was established, the patient disclosed that she had been sexually abused by her biological father since age five, until she became pregnant at age 11 years. At that time the father was sent to prison, the patient underwent elective abortion and her parents divorced. A year later the mother remarried and the stepfather also started abusing the patient sexually. At that point both her mother and stepfather were imprisoned and the patient was taken into state custody, where she has been placed in 13 different foster homes over a two-year period. During that time, she has been occasionally seen by a psychologist and given antidepressant medication. Her main question in our clinic was "I am worthless, nobody likes or wants me, why would you be any different and can you change my life?"

CASE STORY

14 year-old girl referred to our clinic for evaluation of "conduct problems".. According to her mother, during a church sponsored trip, the patient was caught having sex with a male of the same age in the back of the bus, she also had multiple school absences and possible drug use. She has been seen by a psychiatrist and placed on antidepressant medication. In our clinic, the patient stated that "I am a worthless person, why should I go to school".. Ultimately we found out that the father was from eastern Indian origin and the mother a religious fanatic. When the patient was born after unplanned pregnancy, the father refused to marry or to recognize the child until three years later, when he finally married the mother and had two further children. During the patient's life however the father never treated her as his child and always put her down, while loving his other children and treating them well. The mother was always after her, because she is "Godless". The

patient said “I do not like or enjoy sex, I do it hoping to get someone to like me”. The patient is very intelligent and beautiful with very low self-esteem. She feels hopeless, ugly and unloved, but is not planning suicide, because “that is what everybody wants, to get rid of me”. She said: “At least boys care for me, if I have sex with them, but my parents do not no matter what I do”. In response to the question about taking her antidepressant, she says: “Yes, I am taking my medicine daily, but do you really believe that it will make my life better?”

Discussion

Adolescents are basically healthy in the physical sense and most of their morbidity and mortality are due to preventable causes that are the product of risk taking behaviour. This is the result of either poor quality of life, problems in development or combination of multiple factors.

Attempting to help these adolescents with a dogmatic, narrow-minded approach may frequently fail as illustrated by the cases above. Often adolescents present at the clinic with a host of complaints that have nothing to do with their actual problem with the hope of finding help from the physician, who may be able to figure out the real agenda behind their complaints. Over the past three years, a total of 132 adolescents were referred to one of our clinics for evaluation of long lasting recurrent abdominal pain and only three (2.34%) had an actual physical pathology.

The patients in the cases above cannot be helped with a simple approach: you are depressed, here is a prescription for antidepressant and you will attend weekly counselling. Their quality of life is very poor and until that change, they will continue to have problems. The holistic approach to adolescents, helps define their quality of life, find out the underlying causes of their problem and if there is a good social system, that will help alleviate their suffering and provide them with a better quality of life. In a survey of adolescents in Europe, 10% reported having chronic illness and only 10-15% thought they were healthy (28).

Adolescent medicine specialists tend to be more active in screening adolescents for quality of life issues and risk taking behaviours. The initial visit by an adolescent to any clinic, especially to a reproductive health care provider may illicit fear and anxiety among adolescents, however simple guidelines outlined by Burgis and Bacon (1) can help set the ground work for a positive experience for patient and provider.

Tips for an initial visit include, a) an interview that should be conducted with the teen fully clothed, b) an interview with limited interruptions, c) inquiry about and assessment of the home situation, d) learning about the adolescents relationship with parents, peers and school environment. Establishment and maintenance of confidentiality, as well as trust, cannot be over emphasized. A successful visit also encompasses the encouragement of forthright conversations with a parent or trusted adult regarding sexuality.

Adolescents living in a perceived supportive environment report more communication with sexual partners about sexual risks, close relationships with supportive parents seem to be related to later onset of sexual activity and improved contraceptive use. In contrast less frequent parent/adolescent communication is associated with less contraceptive use, lower self-efficacy to negotiate safe sex and less communication between adolescents and their sexual partners (1).

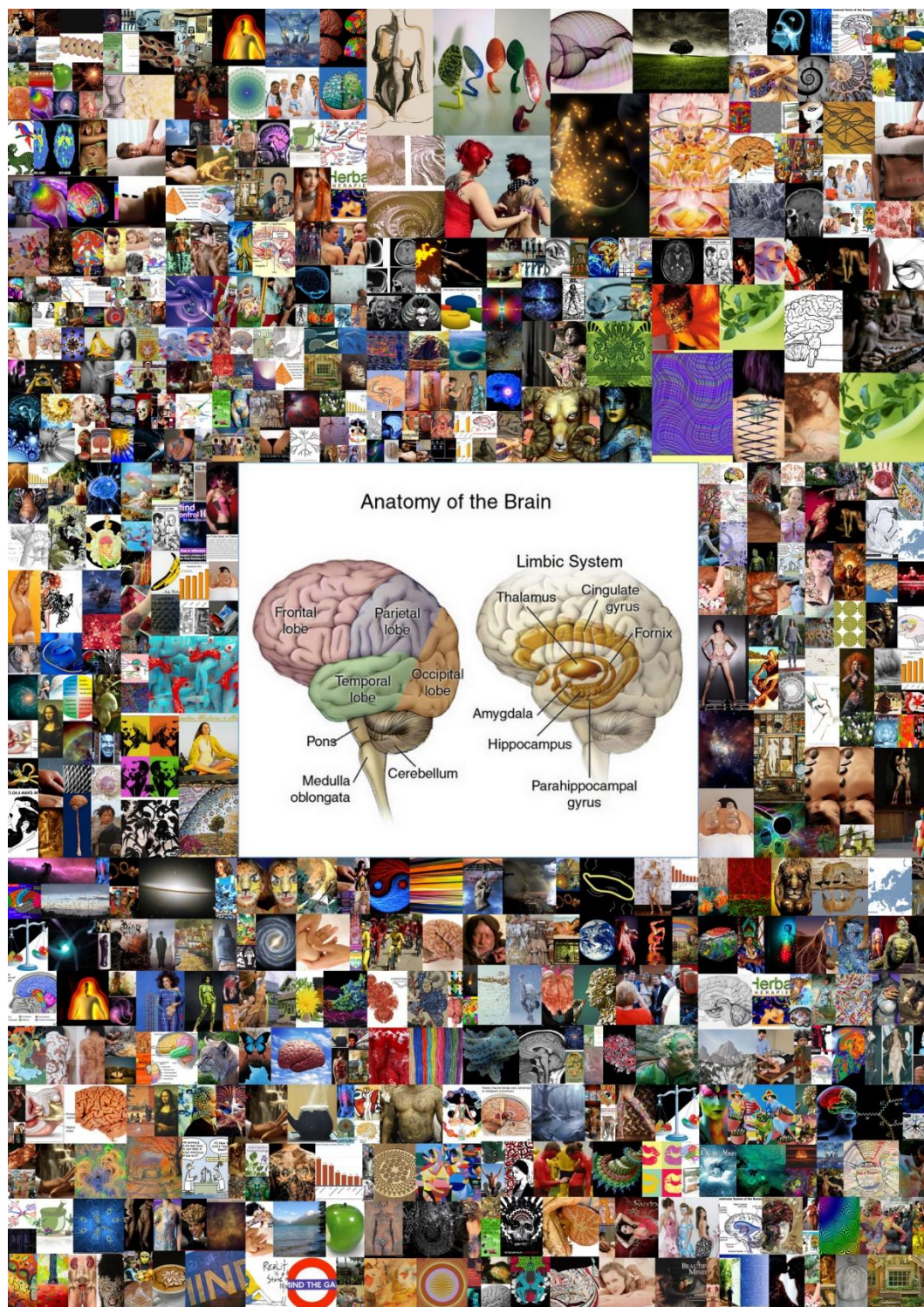
Conclusion

Adolescents are a vulnerable population, undergoing a complicated development. This development occurs in the context of external factors: peers, family, school and society as a whole. Interruption of the normal development process or changes in perceived quality of life may lead to risk taking behaviours above and beyond the usual experimentation by the adolescent and may lead to chronic morbidity or early mortality. A holistic approach to the adolescent that includes investigating quality of life issues and provides proper rapport and caring may help prevent significant mortality and morbidity in this population.

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Eating disorders

Virtually all teenage girls and young women have to some extent an eating disorder, which research has shown to covariate with the intensity of psychosexual developmental disturbances and sexual problems.

We suggest simple psychosexual (psychodynamic) explanations for the most common eating disorders like anorexia nervosa, bulimia nervosa, and binge eating disorder and propose the hypothesis that eating disorders can be easily understood as symptoms of the underlying psychosexual developmental disturbances. We relate the symptoms of the eating disorders to three major strategies for repressing sexuality:

- 1) The dispersion of the flow of sexual energy - from the a) orgasmic potent, genitally mature (“vaginal”) state via the b) more immature, masturbatory (“clitoral”) state, and further into the c) state of infantile autoerotism (“asexual state”).
- 2) The dislocation from the genitals to the other organs of the body, especially the digestive and urinary tract organs (the kidney-bladder-urethra) giving the situation where sexual energy is accumulated and subsequently released through the substituting organs.
- 3) The repression of a) free, natural and joyful sexuality into first b) sadism, and then further into c) masochism.

We conclude that the eating disorders can be understood as sexual energies living their own life in the non-genital body organs, and we present results from the Research Clinic for Holistic Medicine and Sexology, Copenhagen, where eating disorders have been treated with accelerated psychosexual development. We included the patients with eating disorders into the protocol for sexual disturbances and found half these patients to be cured in one year and with 20 sessions of clinical holistic therapy.

Introduction

Virtually every teenage girl on the western hemisphere – and most women between 12 and 35 years– has an eating disorder to some extent. Working as physicians in general practice we

have observed not only a high prevalence of severe eating disorders like anorexia (the general loss of appetite or disinterest in food), anorexia nervosa (the intended weight loss by starvation, over-exercise, purging etc.) and bulimia nervosa (the cyclical, recurring pattern of binge eating often followed by guilt, self-recrimination and compensatory behaviour such as dieting, over-exercising and purging) (see list of the eating disorders listed in ICD-10 in table 1) (1), but also a number of milder disorders that less often are put into diagnoses followed by medical treatment, like binge eating disorder (uncontrolled bursts of overeating followed by compulsive vomiting), extreme and obsessive weight control (often by patients with a normal weight) where the bathroom weight are used several times a day, and obsessive, neurotic attitudes to food i.e. a too large importance attributed to avoiding calories, or carbohydrates, or fat, or even the compulsive abandonment of a single food items like white sugar, white bread etc.

Other expressions of this are extreme exercise-programs sometimes even encouraged by the physician, and vanity that converts into a compulsive drive for being as slim as the commercial fashion-models. The girls often present severely disturbed body images in combination with either an antisocial behavioural pattern with withdrawal and social isolation (antisocial or severely disturbed personality), or a strong dependency on the confirmation of their value as a person from peers and parents (dependent personality type), or a need for constant appraisal of the bodies' sexual value from boys (hypersexual behaviour). So the closer we look at the appetite dysregulations, the more they seem deeply connected to psychosexual factors.

Therapists who work with young female patients with eating disorders often notice that there seem to be both a mental (psychoform) and a bodily (somatoform) aspect of the problem. The patient's mind often carries a lot of thoughts and ideas about the vital importance of not getting too fat and ugly, combined with feelings of shame and guilt from not being able to control the eating habits, etc. The patient's body often seems to live its own life. Sometimes it is compensatory attracted to food, at other times strongly repelled by food, and at other times again not interested in food at all.

Often the phases vary in a cyclic, rather predictable way. In anorexia, food is simply not of any interest; in anorexia nervosa there is a battle in the patient not to eat in spite of an urge for eating; in bulimia we have the compensatory overeating, and in bulimia nervosa we have the inner conflict between one part of the patient that want to eat and another that do not. In binging the striving is for simply filling the stomach and thereafter emptying it totally again, releasing all tension. The emotional character of the eating disorder has made them difficult to treat with behavioural therapy; it has not been able to treat them successfully with drugs either. So most patients suffer from their eating disorder the first 20 years after early puberty; after that is normally tend to burn out – as to the sexual urge.

There are many scientific speculations about biological reasons for the eating disorders - the same way psychiatrists for a hundred years now have speculated in possible biological reasons for mental illnesses; but neither has till this day showed genetic or any other clear scientific evidence for being "hardwired" in the human nature. It is often said that the eating disorders disturb other aspects of the patient's life, including her sexual life, but this is most likely to be the other way round: the eating disorder is a symptom of a deeper psychosexual disturbance. It is worth to speculate that the problems started with puberty and gradually goes down ("burns out") during the next 20 years until the 35-year old woman, who statistically have come to know her body and sexuality by getting rid of her eating disorder, or at least of

its symptoms. The close association in time and intensity is a strong clue that eating disorders might be causally linked to sexuality.

Psychosomatic and psychosexual research has in accordance with this shown sexuality to be closely linked to the eating disorders. Morgan et al (2) found that anorexics were less likely than bulimics to have engaged in masturbation and also scored lower on a measure of sexual esteem, and both groups exhibited less sexual interest and more negative affect during sex than did a normative sample (2). Abraham et al (3) found that bulimic patients were more likely to experience orgasm with masturbation, were more likely to have experimented with anal intercourse, and were more likely to describe their libido as “above average”, while their controls were more likely to experience orgasm during sexual intercourse (3). Raboch and Faltus (4) found that “primary or secondary insufficiencies of sexual life were found for 80% of the anorectic patients”(4), while Raboch (5) found that sexual development of patients with anorexia nervosa was accelerated in the initial stages.

Sarol-Kulka et al (6) found in a pilot study that the anorectic patients showed interest in the opposite sex at an earlier age than patients with bulimia; however, the anorectic females, more frequently than bulimic, reported that these interests were never realized. 36% of patients with anorexia and 29% of patients with bulimia had no sexual initiation. When evaluating the negative aspects of their own sexuality, 28% of patients with bulimia and 9% of patients with anorexia reported difficulties in achieving orgasm; 13% of bulimic and 9% of anorectic females reported difficulties in getting aroused, 22% of bulimic and 17% of anorectic females reported fearing the sexual initiation (6).

**Table 1. The 2007 ICD-10 list of eating disorders and sexual disorders.
Notice the similarities**

(F50.) Eating disorders
(F50.0) Anorexia nervosa
(F50.1) Atypical anorexia nervosa
(F50.2) Bulimia nervosa
(F50.3) Atypical bulimia nervosa
(F50.4) Overeating associated with other psychological disturbances
(F50.5) Vomiting associated with other psychological disturbances
(F50.8) Other eating disorders
(F50.9) Eating disorder, unspecified
 (F52.) Sexual dysfunction, not caused by organic disorder or disease
(F52.0) Lack or loss of sexual desire
(F52.1) Sexual aversion and lack of sexual enjoyment
(F52.2) Failure of genital response
(F52.3) Orgasmic dysfunction
(F52.4) Premature ejaculation
(F52.5) Nonorganic vaginismus
(F52.6) Nonorganic dyspareunia
(F52.7) Excessive sexual drive
(F52.8) Other sexual dysfunction, not caused by organic disorder or disease
(F52.9) Unspecified sexual dysfunction, not caused by organic disorder or disease

Handa et al (7) found that 16.3% of patient with eating disorders had been physically abused and Sanci (8) found that childhood sexual abuse happened 2.5 times as often as normal with patients that later developed bulimia; the patients who developed anorexia did not show this association. Although the picture is not at all clear, and even somewhat contradictory, research has shown a strong association between sexuality and eating disorders. In science we must agree that our present understanding of sexuality is messy and unclear in itself that this most likely is the reason for the messy conditions of the research; we actually believe that it is the incomplete understanding of sexuality itself in the mind of the researchers that is the major hindrance for shedding light into this.

As we aim to improve our present state of understanding we have incorporated into this chapter a number of classical and modern theories of sexuality and psychosexual development. We believe that this synthesis is of clinical value and have, after working 10 years with holistic sexology in the clinic setting (9-25) developed a holistic sexological cure for the eating disorders that we have tested with success on several patients. We therefore want to present our theoretical understanding to make a basis for further research in clinical holistic medicine both in Denmark and in other countries (this chapter is a part of the Open Source Protocol for Clinical Holistic Medicine, that includes all the published strategies for helping the patients with clinical holistic medicine (CHM) and the obtained results from the clinical practice, to be found at www.pubmed.gov, search for papers with “clinical holistic medicine” in the title).

Oral sexuality, sexual repression and eating disorders

The Freudian concept of oral sexuality is little understood by contemporary physicians and psychiatrists (26), but Freud's concept was acknowledged by the whole tradition of psychoanalysts and psychodynamic researchers and therapists from the last century including Jung (27) and Reich (28,29).

CASE STORY

Female patient 36 years old. The patient tells her story about an eating disorder (bulimia nervosa) starting when she was 16 years, a little before she became sexually active. She had this condition until recently – first when she was 30 years old did she have spontaneous remission from it - in spite of many years of cognitive psychotherapy. She was first treated on an individual basis at the University Hospital Psychiatric Clinic; then she came in a bulimia psychotherapy group for 18 month, when she was 20-21 years old, followed by 6 years in individual psychotherapy with a female experienced psychologist. The focus of the therapy was getting control over the eating habits. She reported that she always had big problems with desire, getting sexually aroused, and getting satisfactory orgasm, and she complains about a life-long history of unsatisfactory sexual relationships. She explained that her bingeing was motivated primarily of the extremely relaxed and happy feelings she got after filling her stomach completely until it almost bursted, and then immediately after emptying again completely by vomiting. The process itself was not really emotionally rewarding, neither the eating part of it nor the vomiting part, but the total bodily relaxation was what she was really after. Only after she learned how to relax and go with “the flow in life”, letting go of controlling everything, did the

eating disorder leave her. It seemed that the therapy was unproductive, because it aimed at helping the patient getting control, not at helping the patient to learn to let go of the control.

Freud believed that sexuality during the child's psychosexual development travelled from the mouth to the anus (and bladder), until it reached its final destination in the genitals. Reich had a somewhat different understanding, as he believed that the sexually healthy little girl had genital sexuality, and only when she was denied her "genital rights" i.e. by being punished for masturbation, would she repress her sexuality away from the genitals and into the other organs. Freud also had the idea of sexual development from infantile autoerotism into the more mature masturbatory, clitoral sexual competency, before the girl finally reach genital maturity and able to have sexual intercourse. Reich believed that whenever sexuality became repressed it was kept by the body-amour and the muscles of the body. So when sexuality was repressed, it moved into the tensions of the body, and thus out of reach and use for the patient (28). Today we know in theory three ways for sexuality to become repressed – three neurotic strategies for getting rid of a sexuality that cannot be contained in the patient's childhood environment:

*Repression of sexual energy by destroying the sexual ray of energy:
From the genital state (orgasmic potency) to "infantile autoerotism"
(lack of orgasmic potency)*

The first is the repression of the sexual energy, from flowing freely through the genitals allowing the person so engage in sexual intercourse, to the more restricted masturbatory state, where the sexual energy still can be used for pleasure raising a sexual circle, but only within the person herself, into the still more futile and useless state of infantile autoerotism, where sexual energy cannot any longer form a beam of energy and flow, but only hang as a cloud of sexual energy (a sexual quality or "odor"), just barely allowing the observer to identify the gender of the person. The infantile autoerotism is the typical sexual state of the schizophrenic patient; in psychodynamic theory the lack of sexual interest in the world from this state is one of the suggested reason for autism.

Repression of sexual energy by displacement from the genital to other organs – sexualisation of the digestive system

When sexuality cannot be accepted by the girl's parents it can still survive by being transformed into emotional charge associated with eating, defecation and urination. The mouth, intestines, anus and bladder can, as observed already by Freud carry enormities of charge of sexual energy. The reader that doubts this might recall Gräfenberg study from 1950 where he quite surprisingly documented the very important role of the urethra in many women's sexuality (30). This means that the sexual energies in many ways can be preserved, but disguised, as sexual emotions connected to non-sexual organs; the joy associated with the later is obviously often much easier to accept for the parents: The little girls is cute when she eats; she is even cute when she goes to the bathroom, but she is definitely naughty and not-so-cute when she plays with her own genitals. So the displacement of sexual energies turns her, if she is raised in a sex-negative environment, into a socially acceptable person. If we

compare the eating disorders with the sexual disorders, it is quite interesting to see how parallel these two lists are (see table 1). Of course this psychodynamic understanding of body and sexuality might seem rather incomprehensible, if you are unwilling to acknowledge sexual energies as the fundamental vital energies in the human being, as did Freud, Jung, Reich, and so many of the other great psychologists and physicians of the last century. But if you can follow this scheme of thinking, then you can also examine your female patient presenting an eating disorder for a deeper layer of psychosexual developmental disturbances, that could be corrected, and by doing so you can help the young woman not only to get rid of her eating disorder, but also of other more existentially important problems related to a poorly developed sexuality.

Repression of sexual energy by degeneration into sadism and masochism

A third way sexuality could be repressed is as sadism and masochism. The idea that sexual repression leads to masochism, which is perhaps most strongly and clearly expressed by Reich in his book “Character analysis” (29), is that sexuality basically calls for meeting with the opposite sex, in an active, aggressive way. Sexual aggression is thus the most natural thing with both sexes, although the expression of male and female sexual aggression is very different, the male aggression often looking like sexual violation and harassment, while the female aggression often is looking more like seduction and “hooking”. When sexual aggression becomes blocked, i.e. when the girl is told not to be so sexually challenging to the boys in the way she dresses and acts, or when she is sexually neglected of the father and other boys and men who she is depending on interacting with for her psychosexual development, her sexuality first turns into evil sexual intent (i.e. sexually torturing the boys by rejecting them or slating or intimidating them); the logic in this is that sexuality still exists, because it breaks through the barrier using force (which is sadism). If sadism is also repressed, the flow of sexual energy is turned inwards, instead of outwards (which is masochism). So masochism is basically sadism turned inwards towards self. If the reader wonders how sadism is created from sexual energy turned evil, we refer to our explanation of evilness in general in the life mission theory (31-39). This theory explains how and why all intents seem to turn evil, when they cannot be realized by the little child (36).

Theories for eating disorders

Anorexia nervosa

The basic pattern of anorexia nervosa seems to be the lack of desire and the lack of self-acceptance and acceptance of body and sexuality. The girl often presents severe problems related to her personality; her mind is often not fully developed compared to other girls her age, her sexuality is often less active, unless she uses this as a kind of activity that uses calories i.e. instrumentally and not for the sexual pleasure; spiritually she is often not able to give and receive love, and she often also has a poorly developed self (see (40) for a systematic way to analyze the personality disturbances). So it might be a little simplistic to point to the patients psychosexual development as the fundamental cause of the eating

disorders, but according to psychosomatic theory the problems related to the lack of development of her personality is actually also likely to be caused by her more fundamental problems related to her psychosexual development.

So we do not find it hard to see how anorexia nervosa relates to repressed sexuality; the patient's sexuality is often repressed in several ways: obviously there is often the regression toward the infantile autoerotism; then there is the translocation of sexuality from her genitals to her digestive system (and often also bladder-urethra); and finally there is often a strong component of masochism leading to self-destruction. If the reason for starvation really is masochism, and it often looks so, there is a hidden sexual pleasure in the self-destruction that is stronger than any pain you can inflict on the patient during the most rigorous scheme of behavioural therapy. Actually any scheme that represses the masochistic sexual energy is likely to deprive the female masochistic patient even the last remaining joy and meaning of life. This is likely to be the reason why behaviours coercive therapy, which is still in use in psychiatry, most often is strongly contra-productive.

Bulimia nervosa

Bulimia is in many practical ways the opposite of anorexia, but it still contains from a psychodynamic view many of the same basic elements of repressed sexuality. The shift from the genitals to the digestive organs (and often also bladder-urethra) is the same; the repression of vital sexuality and orgasmic potency into the masturbatory, clitoral state is the same, although the bulimic patient often is less repressed than the anorectic; and the masochistic quality of the bulimic behaviour is often rather obvious. But in bulimia the fundamental drive is preserved. The patient wants to eat; when the patient tells about the strength of the urge it carries the same feel as the other basic biological urges, making it highly likely to be an expression of a hidden sexual urge. If this is the case, it is clear that it is uncontrollable by the girl or young woman. The power of sexuality is stronger than the power of the mind; it cannot be controlled by direct repression; it can only be handled by intelligent negotiation. So if this is the case, the bulimic patient must learn to acknowledge her compensatory drive for eating as an expression of her sexuality; and her neurotic sexuality must be developed to enable it to shift back and inhabit once again her pelvis, genitals - and become a natural sexuality.

Binge eating disorder

This disorder is a less serious disorder that seldom leads to medical attention, as we find it in girls and young women with almost normal psychopathology. In many ways this disorder is the clearest expression of sexuality taken to the digestive system. Instead of filling her vagina she is filling her stomach; and instead of releasing the tension in an orgasm, she releases it through vomiting. Many of these patients seem to have their sexuality repressed to the clitoral level being able to masturbate, but not to have full orgasm during coitus (loss of orgasmic potency). The masochistic component is often lacking, but it can be there also. The simplest way to understand this is the patient masturbating through her digestive system, the same way other women masturbate by filling the vagina and emptying it again; we have noticed the habit of some of these patients to fill their anus and rectum with objects or large amount of

water, and releasing this again for sexual pleasure or for reasons of “purification”. This is obviously the same sexual dynamics taking directly to the intestines. The same way the urine can be held back and finally released as a masturbatory practice of some of these often sexually innovative patients.

The bulimic and the bingeing patients are often sexually active also; not all their sexual energy is channelled to the digestive organs, making the situation a little more complex. It is like a diverted river, where more or less water is running in a parallel river. The cure is to help the patient lead all the water, all the flow of sexuality, back into the main river. First when the patient owns all her sexual energy and is able to use it maturely genitally for satisfying sex with a partner, will her eating disorder – the symptoms of her disturbed sexuality – finally be cured.

Sexological treatment of eating disorders

In treating the eating disorders as sexological disturbances it is important to go directly to the patient’s sexuality; this means that the therapist and the patient should agree completely that her sexuality and personality as a whole is much more important than her eating disorder. Of course, if the patient is dying from starvation or excessive overweight there might be practical problems in using such a strategy; it is important to remember that all problems start as small problems and only if they remain unsolved for a very long time turn into huge, even mortal situations. So this approach is wisely used as soon as the symptoms of the eating disorder appears, not when the girl or young woman has lost so much weight that she is unable to concentrate on anything and close to dying.

The aim of the holistic sexological therapy is the development of the patient’s whole personality through rehabilitation of her sexuality – her genital character – with an often-used expression by Reich (28,29).

Holistic Medicine is nothing but the classical, European medicine going back to Hippocrates; this is the beginning of modern medicine, which we know rather well from uniquely well-preserved sources called the *Corpus Hippocraticum* (41). We have in recent years tried to develop holistic medicine into a modern, scientifically based system of clinical medicine, where patients are cured mostly without drugs and surgery. The theory and practice of clinical holistic medicine has been described in a number of books (42-45) and experimental cures for many illnesses and disorders including cancer and schizophrenia have already been presented in a series of papers (46-75). The sense of coherence seems to be a core concept in the understanding of holistic healing (76-81).

We are not in this chapter going to repeat all the practical tools and details, but the interested physician is encouraged to start just by talking with the patient about her personal history and present problems and after obtaining the trust of the patient continuing this therapeutic work by using therapeutic touch, i.e. massage of the whole body. The combination of the conversational therapy and the bodywork has been used for millennia to rid the patients of repressed emotions hidden in the body or related to the body and sexuality in the patient’s mind. The basic idea in the therapy is to work against the patient’s emotional resistance, to bring all difficult emotions up to the surface of consciousness, but first a variety of emotions will show in the therapy, often sorrow, anxiety, anger, helplessness, hopelessness

or despair. After the emotional layer an even more intense layer of emotions connected to the sexual aspects of the body and its energies, including the genitals and pelvic area will appear.

The holistic sexological bodywork is normally not including the patient's genitals, as many patients can be helped without this degree of intimacy. If the patient is not sufficiently helped there are a number of small and large sexological tools to be used, like acceptance through touch (11) and vaginal physiotherapy (14,15), which are relative small tools and much smaller procedures than the standard pelvic examination, and larger tools like the expanded holistic pelvic examination (13), going all the way up to direct sexual stimulation of the patient in a radical and provocative technique developed 50 years ago by sexologist like Hoch and Reich called the sexological examination (82-92).

The fundamental strategy of therapy is to take the patient back in time, to allow her to confront the emotional and sexual problems of her early life, childhood, and even foetal life if necessary, that she could not solve at that time. The patient will get well again the reverse order of her getting ill – this is the law of Hering (93). The patients will heal her whole existence, not only a part – that is the salutogenic principle (94-95). The patient will come back into the old traumas, when she is exposed, in a symbolic form, for the traumatic events and energies that once created her wounds – that is the famous principle of similarity going all the way back to the ideas of Hippocrates; and finally she will heal when she got the resources needed at the time of the trauma, and is so confident with the therapist that she is able to receive them.

The eating disorders can easily be understood as sexual energies living their own life in the parallel body organs related to digestions, and we present our experience from the Research Clinic for Holistic Medicine that the eating disorders easily can be treated, if therapist and patient can agree that sexuality, not the eating disorder, is the focus of the therapy. In our project we have observed that virtually all young female patients to some degree have an eating disorder; we understand these as symptoms of psychosexual developmental disturbances and we therefore successfully included the patients with eating disorders into the protocol for sexual disturbances (9). We found that about half the patients was cured, not only for their sexual problems, but also systematically from their eating disorders, in one year and with 20 sessions of clinical holistic therapy. In general we found that independently of the type of problem about half the patients were cured, and the more direct the patient's sexuality was approached in the therapy, the more efficient it was (9,15,96).

Ethical considerations

Holistic therapy and holistic sexology should be conducted according to the ethical standard of the International Society for Holistic Health (97) and the laws of the country you reside in. It will be difficult for physicians not familiar with contemporary holistic medicine or the works of Freud, Jung, Reich, Lowen, Rosen and others (26-29,98,99), to understand the full clinical rationality in interpreting the eating disorders as psychosexual disturbances. It will also be difficult for psychiatrists that normally do not touch their patients at all, to understand the therapeutic value of therapeutic touch. And when it comes to using the manual sexological tools, many physicians who are not sexologists, might find these tools too

intimate and too directly sexual. In our clinic we have until now used the small manual sexological tools, and only rarely the holistic pelvic exam. Direct sexual stimulation of the female patients seems to be necessary in primary anorgasmia and similar sexual disorders, but we have not, in spite of the indication, found it correct to use these tools in our clinic, but have referred the patients in need of such therapy to the sexologists using these methods.

When it comes to teenagers below 18 years old, we have chosen to wait with the manual sexological treatment until they could sign up for these treatments themselves as adults legally responsible for their own treatment. For patients below 18 years we have often used the normal pelvic examination as basis for a conversation about sexuality and related issues, and we have found the pelvic examination to be as therapeutic as it is unpleasant and even experienced as “very painful” by 15% of the teenagers (100). We know from several studies that patients with a history of sexual abuse very often react very negative emotionally to the pelvic examination (101); the penetration of the vagina with the speculum and other instruments, or just even the fingers, often gives strong associations to - and memories of the sexual abuse, and according to the principle of similarity this can – and should – be used therapeutically to help the female patient to heal her old wound on body and soul from the sexual abuse (18-20).

Discussion

The observation of the psychoform and somatoform dissociation of the patient will naturally lead to an intent to heal the patient by reconnecting mentally and bodily to the patient. As we are sexual beings, and as a disturbed sexuality has so many symptoms and is followed by so many complications of all kinds, we cannot afford to be a-sexual and to keep all discussion of the patient problems in the a-sexual realm, if we truly want to help the patient.

For almost 100 years psychotherapy and psychiatry have disagreed about the importance of sexuality in mental diseases; this disagreement continues when it comes to the eating disorders. We cannot here settle this old discussion today; just inform the interested reader about the theories and the tools for healing also the patient with an eating disorder. When you have worked for some years in the holistic clinic, as we have now with more than 500 patients, and seen how the dynamics of masochism, sexual repression into autoerotism, and sexual shifts from the genitals to the other organs of the body like the digestive organs (from mouth to anus) and the whole urinary tract (kidney-bladder-urethra) can be easily reversed and often followed by the radical improvement not only of the patient's sexuality, but also of quality of life, physical and mental health, and level of social, sexual and working ability, you will also come to believe in the old psychodynamic theories of Freud and his students. We found it often helpful to teach the patients about quality of life theory (102-105) and quality of life philosophy (106-113).

The sexological approach in the treatment of physical, mental, and existential problems is not new; the traditional holistic medicine of old Greece did exactly that. We have become quite alienated to simple conversational therapy and bodywork during the last five decades, where biomedicine and drugs have become the answer to every problem of the patient, but with biomedicine we have not been able to help all patients and today every second citizen in modern society is a chronic patient, even in countries like Denmark where biomedicine and

health service are absolutely free. So we have to conclude that biomedicine is not going to help all patients and biomedicine is not likely to help teenagers and young women with eating disorders – especially not if the psychodynamic hypothesis presented in this chapter is likely to be true. The most fundamental problem with the sexual approach is that it has proven very difficult to understand the true nature of sexual energy in scientific terms, and that the whole field of human development is theoretically extremely farfetched (114-126). To simplify everything it is important to recall that the essence of relating is being able to say I-Thou. In therapy the courage to love your patient is what in the end will heal you patient and release the patient from disease/pathology (127).

Conclusion

The eating disorders can easily be understood as sexual energies living their own life in the parallel body organs related to digestions and we present our experience from the Research Clinic for Holistic Medicine and Sexology that the eating disorders can be treated, if therapist and patient can agree that sexuality, not the eating disorder, is the focus of the therapy. In our project we have included patients with eating disorders into the protocol for sexual disturbances, and we have found about half the patients to be cured in one year and with 20 sessions of clinical holistic therapy, independent of the problem the patient initially presented with (NNT=2) (9,128-133).

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How to counsel and treat young people to alleviate and prevent sexual problems

Sexuality arises fundamentally from the polarity of our gender. The quality of our sexuality, the mental impression of it, the structure of the desire and patterns of behaviour, seem to be defined by our biology and closely connected to our gender and only slightly modified by our culture. The male sexuality is often said to be outgoing and aggressive, as his biological nature is to spread his semen and the female sexuality is receptive and limiting, as she has to choose the right partner for her offspring. From a biological perspective this makes good sense. In this chapter we try to analyse the nature of sexuality from the qualitative perspective of motivation.

Introduction

Caroline Free points to an issue of extreme importance in her editorial on “Advice about sexual health for young people” (1). Combining the fact that more than a quarter of young people are sexually active before they are 16 years of age, that one in ten suffer from severe sexual problems and half of them from minor sexual problems, the need for counselling and supporting the teenager in the sexual area is obvious.

Sexuality remains the biggest taboo in society and in the medical community this taboo is the constant fear of losing the license, if the physician is accused of overstepping boundaries. The development in most western societies has for decades been towards a more open attitude towards sexuality and pornography with an earlier sexual debut, that today in the Nordic countries, England and USA find teenagers aged only 13, 14 and 15 years highly sexually active and often much more experimental than their parents have ever been. From our clinical experience, sexual problems are almost always both in the young teenager and in the young adult related to existential and emotional problems.

Therefore a holistic approach seems appropriate focusing at the same time both on the physical, emotional and existential aspects of the sexual problems.

Often solving the existential problems causing the sexual inadequacy is the key to a permanent solution. This means that an open and honest dialog with a non-judging and accepting attitude can benefit the teenager for life. Many or maybe most sexual problems can simply be prevented, if the physician takes time to give thorough counselling and even sexological treatment to the teenager, when needed.

The conversation is so far the most important tool for helping the teenager, educating him or her in the fundamental dimensions of existence and sexuality and the correspondence between these dimensions. What is so desperately needed by the physician is the words, structure and understanding of both sexuality and the existence, so he can educate the teenager, who more than anything needs understanding.

Holistic sexology for teenagers

The scientific breakthrough in the understanding of human sexuality came with Masters and Johnson's brilliant work in the middle of the last century (2,3). The most famous curve in sexological research is still the curve of the male and female sexual reaction cycles, explaining the four phases of the normal sexual intercourse: the excitement phase, the plateau phase, the orgasmic phase and the relaxation phase. Since their work, most clinical sexologists have recognised a pre-phase of lust, where one of the most dominant problems of our time is the lack of sexual lust in females (4).

In spite of this excellent description of sexual experience and behaviour, we still lack a sufficient theory of sexuality that can serve as guidance for the sexologic therapy, especially when we in the holistic sexological clinic want to treat the whole person and overview all the relevant dimensions of sexuality and existence, as is often the case when we want to help the teenager.

We want the teenager to be a whole, balanced, ethical and able person, not just to be able to function sexually. As sexual and existential problems often go hand in hand and as both existence and sexuality is theoretically difficult issues, the two maybe most fundamental questions of the research in human life and quality of life are: "what is existence?" and "what is sexuality?"

Often the first question are left unanswered and the second met with theoretical answers from evolutionary theory and psychosocial models (5,6), but difficult to use in sexual education as well as in the sexological clinic with the teenager. We want to make up for this lack of a comprehensive theory of sexuality by introducing an existentially oriented theory of sexuality, taking its basis in the life mission theory (7-13) of human existence.

The useful thing of having two strongly related theories for both existence and sexuality is that it becomes easy to work with both sexuality and existence at the same time in the holistic clinic, as the physician often must to help the patient, both the patient with sexual problems and the patient with existential problems.

The theory of existence and the theory of sexuality

According to the theory of talent (10) the human being has three fundamental dimensions of existence:

- Purpose of life – giving meaning, happiness, existential and spiritual satisfaction
- Gender and sexuality – giving joy and sensual pleasure, sensual satisfaction
- Power in mind, feelings and body – giving fun and success, mental satisfaction

Purpose of life

The dimension of purpose of life, also called love, or primary talent, arise according to the life mission theory (7-13) from human choice. The life mission theory is a theory of the purpose of life, which integrates neo-Freudian, existential and transpersonal models. It explains in general the loss of health, quality of life and ability of human beings to function optimally. It states, that our human nature gives us choice, that is freedom to an autonomous intention, and that our first intentional choice becomes our purpose of life. This intention of our wholeness, or soul if you like, sets the fundamental perspective of the person, which again gives birth to the personality and a consciousness mind, that is the structure of interpretation of the world (the consciousness is in our understanding basically based on our cellular biology, giving rise to a purpose of life, and other intentions) (14-20).

The fundamental differences in worldview give human beings their fundamental difficulties in understanding each other. We all have a very personal perspective of reality and only when we realise how deep down this goes, to the bottom of our totality, or soul, can we understand the other, patient or peer. Only when we know ourselves to the very bottom of our soul, including all aspects of our character (13) and purpose of life (7-13), can we truly know the other. When we rehabilitate the purpose of life and human character, we rehabilitate the person's ability to be coherent with the world at large (21,22), that is, our ability to love, our ability to exist on a spiritual level – function on an abstract level of existence – and to use our central talents to be of value to the other.

The dimension of power comes from the biological fact that we all have a mind, feelings, and emotions, where rehabilitating this dimension is important because of the fact that we often need to modify our self and restrict our own power in order to be tolerated and accepted by our parents. If we as children and teenagers are too powerful and dominating, we are often meet with rejection, neglect, violation (11), so we have to deny our own intelligence, feelings or bodily presence. While these two dimensions with the presented theories are fairly well understood, we have yet to explain the third dimension of gender and sexuality. The dimensions of love and power must relate to the dimension of sexuality, for us to lead a whole, balanced and successful life.

The physician must always, when evaluating a teenager's sexual relationship, reflect on the ethical side of sexuality or answering the question: when is a sexual relationship harmful to the patient? If the relationship is seen as harmful, harm must be prevented. The best way is

to make the teenager understand what causes the harm and letting go of this part of the relationship or of the sexual partner when necessary. Without educating the teenager to be able to protect herself, the harm can only be temporarily avoided; if a negative pattern is there, the harm is likely to happen later. Prevention of sexual abuse is thus possible in many cases.

What is sexuality?

Sexuality arises fundamentally from the polarity of our gender. The quality of our sexuality, the mental impression of it, the structure of the desire and patterns of behaviour, seem to be defined by our biology and is closely connected to our gender and only slightly modified by our culture. The male sexuality is often said to be outgoing and aggressive, as his biological nature is to spread his semen and the female sexuality is receptive and limiting, as she has to choose the right partner for her offspring. From a biological perspective this makes good sense. We suggest that we analyse the nature of sexuality from the qualitative perspective of motivation and we thus find the following nine reasons for human beings to engage in sexual activity:

- Reproduction: To have children or to give children
- Sensual enjoyment
- Love: As an expression of love, including spiritual and developmental reasons.
- Fun (power games): either to give or receive it, or not to give or not to receive it, as an entertainment, reward or punishment.
- Dependency of sex (substituting meaning in life and love, often after incest or sexual abuse in childhood) (24)
- Prostitution: To trade it for material or immaterial values (money, food, accommodation, drugs, safety, protection, and more)
- Manipulation: social pressure, seduction (abuse, group pressure, societal prestige, incest, and professional incest)
- Rape: to exploit the lack of resistance (lack of mental, emotional or physical power)
- To do evil (to consciously or unconsciously revenge wrongdoings towards self, or just to materialise an evil intention) (12)

Only the first two are directly related to the existential dimension of gender and sexuality. The enjoyment is obviously closely related to the intent and behaviour of reproduction, and it is normally suggested that this activity is rewarded by the organism releasing a morphine-like substance in the brain (25). While the objective meaning of reproduction is easily understood, the subjective dimension of joy is much more difficult to comprehend. The joy can be understood as a biological reward system connected to reproduction, but as the female interest in and enjoyment of sex often starts long before and continues long after the menopause, this is not a very good explanation. The real mystery about sex obviously lies in understanding the biological and existential source of the sexual pleasure, which seems to be

connected to all living being, going all the way down the eukaryot cell's path of evolution to the bacteria's strong interest in foreign genes (please see the discussion below).

What are the dimensions of sexual enjoyment?

The sensual enjoyment in sexuality is traditionally described to have the following dimensions (2,3,26-33): Lust is basically an expression of the wish to have sex, which is the intention of sex. Excitement is basically the mind, feelings and body getting involved with sex. Pleasure is the enjoyment coming from the female and the male pole meeting.

Orgasm is lust, excitement, and pleasure culminating in a peak (peak orgasm), which can be prolonged into a plateau of intensity (plateau orgasm); the multi-orgasmic experience which is natural with woman and obtainable for more men with tantric exercises is a somewhat dynamic combination of these two.

The orgasm can be local, located to the genitals and pelvis, or more global, or all including, often deathlike, and transcendent experience.

Orgasmic potency is the ability to get a high level of intensity, prolonged orgasms, more orgasms, and all-including, transcending orgasms. Interestingly, for women orgasmic potency seems to be the inverse of the time needed in the Master and Johnson's plateau phase; the more orgasmic potent, the less time you need to spend in the plateau phase before you reach orgasm; for men it is actually the same but orgasmic potency is also direct proportional with the time the man can hold his ejaculation back, as he can build a high intensity of pleasure/orgasm without letting go of the "tension" (the sexual polarity), this being the secret of the multi-orgasmic man.

Tantra. The orgasm has two components of pleasure, one is the sensual pleasure rising to its peak, and the other is the existential satisfaction of reproduction – giving and receiving the semen and thus creating a baby.

When consciousness develops to a certain level, the existential satisfactory part of the normal, re-creative and non-reproductive sexual act is seen to be balanced with an existential frustration a moment after, when it is realised that reproduction does not follow the intercourse. The conscious person will then let go of this part of the sexual pleasure, reorganising sexuality into the classical tantric path.

Correspondence of dimensions. Interestingly, the three above mentioned dimensions of sexuality fits well into the general theory of talent (10): lust arises from intention, excitement from power (freedom and liveliness of mind, feelings and body), and pleasure from the dimension of gender. Orgasm comes from the combination of lust, excitement, and pleasure, but only if the individual can let go of the mind and transcend into being fully a life.

Sexual health depends thus on the ability to allow oneself to experience the maximal level of sexual desire, and at the same time to completely control the level of sexual excitement and behaviour; this is rehabilitated together with the ability to know and be your true self in the course of personal, existentially oriented development.

The ability to desire is rehabilitated together with your general purpose of life, which is your fundamental source of lust for life. The ability to get a high level of excitement is rehabilitated when your full personal power is rehabilitated, so you can involve your mind, your feelings and your body a 100% in the sexual act. Sensual pleasure is rehabilitated when

the ability to sensual enjoyment in all areas of life is fully rehabilitated, together with your general self-esteem and your ability to embrace a strong sexual polarity, being fully the male or the female sexual pole. Orgasmic potency is rehabilitated, when lust, excitement, and pleasure is rehabilitated, together with the ability to let go of the ego and transcend.

Table 1. Nine key dimensions of existence, which exist in a passive and an active form, corresponding to the being and doing of life

	Active form	Passive form
1. Coherence, the web, the nest of the world	Receiving, taking in	Being an integrated part
2. Intent/purpose of life	Intention, decision	Having a purpose (of life)
3. Talent/strength	Using skills and urges	Having strength and structure
4. Consciousness	Noticing, knowing, understanding, planning	Being awake
5. Love	Acting in love	Being in love
6. Sex/physicality	Meeting, enjoying	Being man/woman of character
7. Light	Bringing light	Being in light/enlightened
8. Joy	Bringing joy	Being in joy
9. Meaning/QOL	Creating/fulfilling life, giving	Being alive, having impact

Relevance to holistic sexological therapy

Nothing is as practical as a good theory and especially if this theory supports the intervention on the sexually dysfunctional teenager male or female. What needs to be done is always the rehabilitation of lust, excitement, sensual enjoyment and orgasmic potency, together with the processing of tensions, aches, pain and discomfort. This pain is often caused by the feelings from negative life events related to sex and gender, which were at that time repressed and placed in body and mind as blockages, specifically in the pelvis and the sexual organs and tissues (34-37).

The four standard steps of holistic existential therapy: love, trust, holding and healing are more needed with the vulnerable and insecure teenager that with any other patient. Holding consist of awareness, respect, care, acknowledgement and acceptance and when it comes to sexual problems acceptance is often the most important of these five. The lack of self-acceptance is primarily felt as shame and low self-esteem. The most efficient procedure in holistic sexological therapy to solve problems with shame seems to be acceptance through touch (35). Using this kind of holistic therapy with young teenagers is ethically highly problematic and must always be justified by a strong medical necessity like unbearable vulvodynia as an alternative to surgery or strong lifelong medication and done by physicians, which masters a high degree of self-control and self-insight. Conversation is therefore in general the preferred holistic medical tool in the holistic sexologic clinic with the young teenagers.

In general, sexual problems cannot be solved without a partial focus on existential issues and this is more so with teenagers, which are normally going through so many deep existential crisis. Many young patients will when sexually active present existential problems as sexual problems, as sexual dysfunction, lack of lust, and lack of orgasmic potency is often

the most noticeable subjective symptom of poor quality of life and low self-esteem. In older patients this pattern is reversed; often they do not expect to function sexually, but they complain of lack of lust for life in general. Often the rehabilitation of sexuality and character (11) is the path to insight in self and the purpose of life, the essence of self (7-13).

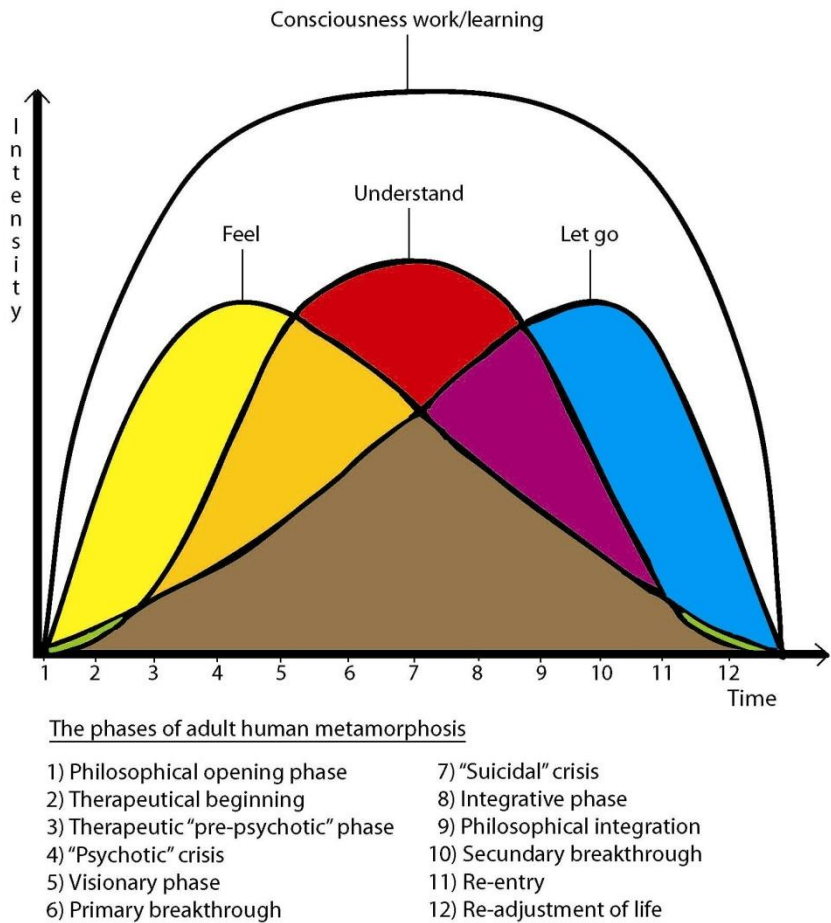


Figure 1. The process of holistic healing seen as three phases of feeling (yellow), understanding (red), and letting go (blue) of negative beliefs, attitudes, and decisions. As an end result, the process was improving the patient's philosophy of life and thus allowed the patient to rebalance existence and to assume responsibility for life. During the process, the patient's will re-established quality of life, health, and existential coherence, along with the ability to love, understand, and enjoy the whole spectrum of feelings and emotions, including sexuality.

Sexual ethics and medical ethics for working with the teenager

With the mapping of the three experiential dimensions of sexuality leading to the transcending experience of orgasm, it is possible to analyse what is necessary for a high sexual ethics needed for working with the vulnerable teenager.

As most people are unaware of their most fundamental intentions, most people cannot control lust. The holistic physician comes from a clear intention of being there for the patient in the same way as a good parent, and this is an efficient means of controlling intention, making the intention of helping, healing and supporting the patient his/her sole focus; to accomplish this to a degree where sexual desire and other unwanted intentions does not appear anymore, which is one of the signs of mastery of the holistic medical clinical practice.

As the sexual polarity is an innate quality, the sensual enjoyment connected to the mere contact with a person of the opposite sex can be diminished by repressing ones sexual poles (male or female); as the repression of one's own gender in the clinic often will be somewhat irreversible and therefore leave a degree of permanent sexual inhibition, this strategy of controlling sexuality is damaging to sexual health, and to ones character in general (11) it cannot be recommended.

Interestingly, as according to the presented sexual theory, sexual excitement comes from investing mind, emotion and body in sexuality, excitement is completely controllable. This means that instead of just controlling ones sexual behaviour, a person or a physician can chose not to get sexually excited, even if the desire in itself cannot be controlled. After some practice sexual excitement can easily be controlled in the holistic medical clinic, making it possible to obtain extreme intimacy without getting sexually involved (35,37), which is of extreme importance in the adolescent holistic sexologic clinic.

The interesting consequence on this is that practical sexual ethics can be taught both to patients and to their physicians. We suggest that this ability of getting intimate with the opposite sex without getting sexually excited should be an obligatory part of every physician's medical training, as physical intimacy is a natural part of the doctor's job. The physician still needs to carefully control his behaviour too, as the patient still will interpret the behaviour of the physician, and a patient should never feel sexually abused. In our experience any person, man or woman, will normally take an appreciation, when expressed verbally or non-verbally without any sexual excitement, as a compliment, while the same appreciation, when expressed with such an excitement, often will be taken as a flirt and invitation to a sexual relationship, or as a sexual harassment or even a sexual violation.

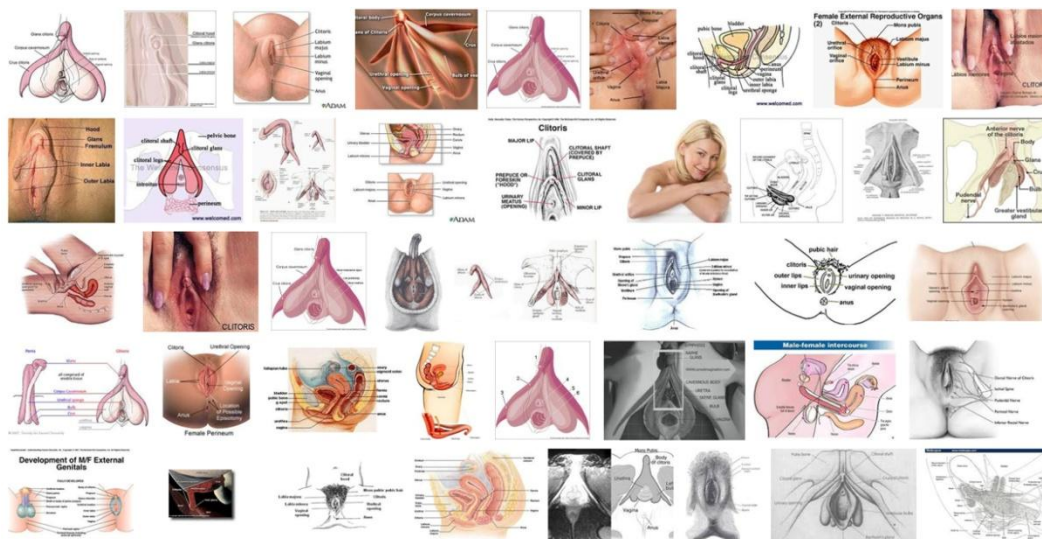
The highest degree of responsibility that a physician can take is the responsibility for the experience of the patient; in holistic existential therapy and sexology where painful old emotions are confronted and integrated an important competence is the physician's mastery of the patients experience, calling old painful moments into this moment, while letting the patient clearly know and experience, that the intention of this is solely the healing of the patient. The physician being completely relaxed and without any sexual excitement and emotional tension, giving the patient through an honest appreciation the feeling of being a well-respected, autonomous, precious, and whole being, is an important precondition for this kind of therapy (41,42).

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Psychosomatic reasons for chronic pain

We have often seen a connection between earlier sexual abuse and chronic pain, both related to sexuality and genitals and not related to these issues. We believe that the pain comes from strong negative emotions repressed into the body and the unconscious by the person in the emotionally painful moment of abuse. In holistic therapy, where the focus is on integrating body, feelings, and mind, we often find such feelings “hidden in the tissues and organs of the body,” causing not only pain but also actual disease, even though the person him-herself have not been aware of the connection or even repressed the earlier trauma. In a multidisciplinary treatment of a patient with chronic pain, it is therefore necessary to remain open to the possibility that the cause may not be visible initially and that it may indeed be the expression of earlier childhood trauma.

Introduction

Some research has shown that “college students with chronic pain yielded a history of abuse (physical and/or sexual) in 43.5% of the females (275 subjects) and 23.8% of the males (151 subjects)” (1,2). We suggest that as many victims of sexual abuse repress their memory of the incident(s), the actual number of those with chronic pain, who have been abused may in fact be even higher.

The most likely reason for this connection between abuse and chronic pain is the notion that strong negative emotions are repressed by the person in the emotionally painful moment of abuse. In holistic therapy, where the focus is on integrating body, feelings, and mind, we often find such feelings “hidden in the tissues and organs of the body,” causing not only pain but also actual disease (3–7). In a multidisciplinary treatment of a patient with chronic pain, it is therefore necessary to remain open to the possibility that the root cause may not be visible initially and that it may indeed be quite ugly.

One important conclusion reached (1) was that “clinicians should routinely ask chronic pain patients about any history of past or present abuse.” This inquiry is correct and very important, regardless of the presence of chronic pain. As severe cases will often be buried in

shame, however, the physician is not likely to obtain this knowledge without first attaining a mutual level of trust and confidence with the patient(8).

Personal development, improvement of the quality of life, awareness of deep existential dimensions and purpose of life are all concepts that need to be addressed in the empowerment of the patient and that will subsequently help him or her deal with the pain (9).

There is also the need for a new language for pain. The often-used expression “nonanatomic pain,” for example, is impractical, as most pains is diffused throughout the patient’s internal body image, even when the cause is indeed somatic. When physically exploring the cause of the pain, the physician needs to help the patient understand the location, quality, and nature of the pain. Such an understanding often transforms a diffuse, chronic, “nonanatomic” pain into one that is well defined and localized. When presented to the patient, the pain may even change in quality and location as the psychological significance and meaning are addressed. This process of “confronting the pain in the body” is an important aspect of healing chronic pain in a holistic/multidisciplinary clinic (8). Indeed, it is therapeutic in its own right, because a local, focused and “understandable” pain is much more manageable for the patient than a diffuse pain. Because it is possible that a psychosomatic, emotional element is present in many diseases, we would therefore like to propose a new distinction in the linguistics of pain; pain that cannot be localized and attributed to an organic origin should be termed “primary,” whereas those pains that can be identified and associated with an organic source should be labelled “secondary.” The issue is complicated, for an organic pain, such as a chronic infection, may well be caused by trauma, which thus “blocks” the region of the patient’s body and duly disturbs immune system regulation.

Processing the patient’s complicated and repressed feelings of guilt, fear, and shame is often very helpful in alleviating chronic pains in the holistic medical and sexological clinic. What are urgently needed are tools that will help general practitioners and other therapists and sexologists address this suppression; this processing is especially important in the treatment of adolescents and young adults. We believe that a holistic approach to both existence and sexuality will help us, as physicians and sexologists, heal many pains and problems of psychosomatic origin in the future (10).

Acknowledgment

This chapter is based on original ideas that were peer reviewed and published earlier in: Ventegodt S, Merrick J. Psychosomatic reasons for chronic pains. *South Med J* 2005;98(11):1063.

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Pain and pleasure in sexuality

In order to understand sexuality from a psychological point of view, the positive sexual experience must be analysed into its components of desire, excitement and pleasure. The three components melt together in the experience of climax that can be orgasm, where tension is released. Another perspective on the same is focusing of the ecstasy, that rises where there is an inner meeting between the male and the female pole of the person (compare with Jung's theory of anima/animus).

The three above-mentioned dimensions of sexuality fits well into the holistic model of *body, mind and spirit* with *desire* arising from spirit and intention, *excitement* from power and mind, and *pleasure* from the dimension of gender and body.

Sexuality thus seems to be flowing through all aspects of the human being. Sexual pain seems to be the most intense suffering possible, and sexual humiliation like rape and forced sodomy are often used tools of torture. *Sexual pain* can be understood as the inversed experience of orgasm.

In this chapter we present sexual theory and sexual motivations and try to shed light on problems related to desire, excitement, pleasure/orgasm, sexually related pain, vaginismus, vulvodynia, impotence, premature ejaculation, adultery, the use of prostitutes, pornography, homosexuality, incest, paedophilia, child pornography, rape, sado-masochism, and sexual torture and murder.

Introduction

Sexuality is known to be the most intense source both to pleasure and pain, but why is sexuality so potentially painful? A possible answer is that sexuality is the source of the most intense pleasure a human being can experience; therefore by reversing the experience it can be turned into the most intense of sufferings.

The scientific breakthrough in understanding human sexuality came with Masters and Johnson's brilliant work in the middle of the last century (1,2). The most famous curve in sexological research is still the Reichian curves of the male and female sexual reaction cycles, explaining the four phases of the normal sexual intercourse: the excitement phase, the plateau phase, the orgasmic phase, and the relaxation phase.

Since this work, most clinical sexologists have recognised a pre-phase of desire and lust, where one of the most dominant problems of our time is the lack of sexual desire in females (3-8). In spite of this excellent description of sexual experience and behaviour, we still lack a sufficient theory of sexuality that can serve as guidance in sex therapy, especially when we in the holistic clinic want to treat the whole person and view all the relevant dimensions of sexuality and existence (9-11). A most important fact seems to be that the sexual part of us carry most of our repressed emotional charge, which must be integrated in the treatment with holistic medicine (CHM) and sexology.

As sexual and existential problems often goes hand in hand, and as both existence and sexuality is theoretically difficult issues, the two maybe most fundamental questions of the research in human life and quality of life are: “what is existence?” and “what is sexuality?” Often the first question are left unanswered, and the second met with theoretical answers from evolutionary theory and psychosocial models (12) difficult to use in sexual education (13,14) as well as in the sexological clinic.

In this chapter we want to make up for this lack of comprehensive theory of sexuality by introducing an existentially oriented theory of sexuality based on the life mission theory (15-22) of human existence, and using this to explain sexual pain and pleasure. The useful thing of having two strongly related theories for both existence and sexuality is that it becomes easy to work with both sexuality and existence at the same time in the holistic clinic, as the physician often must help the patient with both the sexual problems and the existential problems.

Before publishing this theory we tested its clinical usefulness and found that 14 one hour sessions of holistic sexual therapy as outlined in this chapter (see also 23-25) can help 41,1% of patients, who experienced severely compromised sexual functioning (26). An alternative, intensive therapy also based on the presented theory could help 56% of the chronic patients, who did not respond to other treatments (27-29).

The theory of existence and the theory of sexuality

According to the theory of talent (18), mankind has three fundamental dimensions of existence:

- Purpose of life – giving meaning, happiness, existential and spiritual satisfaction
- Gender and sexuality – giving joy and sensual pleasure, sensual satisfaction
- Power in mind, feelings and body – giving fun and success, mental satisfaction

Most interesting it seems that sexuality is so closely connected with the fundamental energy of life that sexual energies are circulated though all layers of our existence, body, mind and spirit. Because of the integrative nature of sexuality, existential suffering and sexual pain is very closely connected, as is existential joy and sexual pleasure.

The dimension of purpose of life, also called love, or primary talent, arise due to human choice according to the life mission theory (16,18). The life mission theory (16) is a theory of the purpose of life, which according to one researcher integrate neo-Freudian, existential and

transpersonal models (30). It explains in general the loss of health, quality of life and ability of human beings. This theory states, that our human nature provides us with a choice or freedom to an autonomous intention and our first intentional choice becomes our purpose of life. This intention of our wholeness, or soul if you like, sets the fundamental perspective of the person, which again gives birth to the personality and a consciousness mind, that is the structure of interpretation of the world (see how the consciousness is based on intention in (31-37)).

The fundamental differences in worldview give human beings their fundamental difficulties in understanding each other. We all have a very personal perspective on reality, and only when we realise how deep down this goes, to the bottom of our totality, or soul, can we understand the other, patient or peer. Only when we know ourselves to the very bottom of our soul, including all aspects of our character (21) and purpose of life (18), can we know the other.

When we rehabilitate the purpose of life and character, we rehabilitate the person's ability to be coherent with the world at large (22,38,39). Or in other words, our ability to love, our ability to exist on a spiritual level – to be on an abstract level of existence – and to use our central talents to be of value to others. All happiness arises according to this theory from realising your purpose of life, and all suffering arises from not being able to do so.

The dimension of power comes from the biological fact that we all have a mind, feelings, and emotions, but rehabilitating this dimension is important, because of the sad fact that we often need to modify our self and restrict our own power to be tolerated and accepted by our parents. If we are too powerful and dominating we are met with rejection, neglect, violation etc, so we have to deny our own intelligence, feelings, bodily presence etc.

While these two dimensions with the presented theories are fairly well understood, we have yet to explain the third dimension of gender and sexuality, which is the aim of this chapter. We will also explore how the dimensions of love and power must relate to the dimension of sexuality, for us to lead a whole, balanced and successful life.

What is sexuality?

Sexuality is believed to arise from the polarity of our gender. The quality of our sexuality, the mental impression of it, the structure of the desire and patterns of behaviour, seem to be defined by our biology and is closely connected to our gender, and only slightly modified by our culture. The male sexuality is often said to be outgoing, and aggressive, as the male biological nature is to spread his semen, and the female sexuality is receptive, and limiting, as she has to choose the right partner for her offspring. From a biological perspective this makes good sense. Later in this chapter we will discuss this in more details, as these considerations are of a more speculative nature. We suggest analysing the nature of sexuality from the qualitative perspective of motivation, and we thus find the following nine reasons for human beings to engage in sexual activity:

- Reproduction: To have children or to give children
- Sensual enjoyment
- Love: As an expression of love, including spiritual and developmental reasons.

- Fun (power games): either to give or receive it, or not to give or not to receive it, as an entertainment, reward or punishment.
- Dependency of sex (substituting meaning in life and love, often after incest or sexual abuse in childhood) (40)
- Prostitution: To trade it for material or immaterial values (money, food, accommodation, drugs, safety, protection, and more)
- Manipulation: social pressure, seduction (abuse, group pressure, societal prestige, incest, and professional incest)
- Rape: to exploit the lack of resistance (lack of mental, emotional or physical power)
- To do evil (to consciously or unconsciously revenge wrongdoings towards self, or just to materialise an evil intention (20)

Only the first two are directly related to the existential dimension of gender and sexuality. The enjoyment is obviously closely related to the intent and behaviour of reproduction and it is normally suggested that this activity is rewarded by the organism releasing morphine-like substances in the brain (41). While the objective meaning of reproduction is easily understood, the subjective dimension of joy is much more difficult to comprehend. The joy can be understood as a biological reward system connected to reproduction, but as the female interest in and enjoyment of sex often starts long before and continues long after the menopause, this is not a very good explanation. The real mystery about sex obviously lies in understanding the biological and existential source of the sexual pleasure, which seems to be connected to all living being, going all the way down the eukaryot cell's path of evolution to the bacteria's strong interest in foreign genes (please see the discussion below).

What are the dimensions of sexual enjoyment?

The sensual enjoyment in sexuality is traditionally described to have the following dimensions (1,2,6-9):

1. Desire is basically an expression of the wish to have sex, which is the intention of sex.
2. Excitement is basically the mind, feelings and body getting involved with sex.
3. Pleasure is the enjoyment coming from the female and the male pole meeting.

Orgasm is lust, excitement, and pleasure culminating in a peak (peak orgasm), which can be prolonged into a plateau of intensity (silent ecstasy, plateau orgasm); the multi-orgasmic experience, which is natural with women and obtainable for more men with tantric exercises, is a somewhat dynamic combination of these two. The orgasm can, depending on the person's level of sexual development, be local, located to the genitals and pelvis, or more global, or all including, often deathlike, and transcendent experience. It is now generally believed that women can have a male extrovert-type clitoral orgasm sometimes with squirt, and a female, introvert type, called vaginal orgasm, depending on the orientation of her sexual flow of energy in the body.

A person with frustrated desire is basically not succeeding in having sex, which is failing the intention of sex. Lack of excitement is basically the mind, feelings and body not being able to get involved with sex. Lack of pleasure is not enjoying the female and the male pole meeting. Sexual pain, disgust, and humiliation arise from abuse and repression of sexuality.

Orgasmic potency is the ability to get a high level of intensity, prolonged orgasms, more orgasms, and all-including, transcending orgasms. Interestingly, for women orgasmic potency seems to be the inverse of the time needed in the Master and Johnson's plateau phase; the more orgasmic potent, the less time you need to spend in the plateau phase before you reach orgasm. For men it is actually the same, but orgasmic potency is also directly proportional with the time the man can hold his ejaculation back, as he can build a high intensity of pleasure/orgasm without letting go of the "tension" (the sexual polarity), this being the secret of the multi-orgasmic man.

Tantra. The orgasm has two components of pleasure, one is the sensual pleasure rising to its peak, and the other is the existential satisfaction of reproduction – giving and receiving the semen and thus making a baby. When consciousness develops to a certain level, the existential satisfactory part of the normal, re-creative and non-reproductive sexual act is seen to be balanced with an existential frustration a moment after, when it is realised that reproduction does not follow the intercourse. The conscious person will then let go of this part of the sexual pleasure, reorganising sexuality into the classical tantric path.

Correspondence of dimensions. Interestingly, the three above mentioned dimensions of sexuality fits well into the general theory of talent (18): lust arises from intention, excitement from power (freedom and liveliness of mind, feelings and body), and pleasure from the dimension of gender. Orgasm comes from the combination of lust, excitement, and pleasure, but only if the individual can let go of the mind and transcend into being fully alive.

Sexual health depends thus on the ability to allow oneself to experience the maximal level of sexual desire, and in the same time to completely control your level of sexual excitement and behaviour. This is rehabilitated together with the ability to know and be your true self in the course of personal, existentially oriented development.

Sexual health is easily measured by the four questions of the "Sexual Health Scale", rated on a five point Likert Scale (1: very good, 2: good, 3: neither good nor bad, 4: bad, 5: very bad; Comp. QOL5 (42)):

1. How would you rate your ability to feel desire these days?
2. How would you rate your ability to get sexually exited these days?
3. How would you rate your ability to enjoy sexual contact these days?
4. How would you rate your ability to obtain orgasm these days?

Sexual health is easily calculated as an average of these four questions. The questionnaire has not yet been validated, but has shown its usefulness in the holistic sexological clinic as a tool for screening for sexual problems and opening for the therapeutic conversation.

The ability to feel desire is rehabilitated together with your general purpose of life, which is your fundamental source of lust for life. The ability to get a high level of excitement is rehabilitated, when your full personal power is rehabilitated, so you can involve your mind, your feelings and your body a 100% in the sexual act. Sensual pleasure is rehabilitated when the ability to sensual enjoyment in all areas of life is fully rehabilitated, together with your general self-esteem and your ability to embrace a strong sexual polarity, being fully the male

or the female sexual pole. Orgasmic potency is rehabilitated, when lust, excitement, and pleasure are rehabilitated, together with the ability to let go of the ego and transcend.

What is orgasm, sexual enjoyment and enjoyment in general?

Wilhelm Reich explained orgasm as the pleasure of releasing a tension build up under the sexual act (43). This theory is widely accepted today, but it is not easy to understand this theory if one goes deep into the mechanisms: why is a “sexual tension” build in the first place and why is the release of this so emotionally rewarding? Normally tension builds in the body to avoid pain, and the release of this tension reveals the pain hidden in the tension. It is true that most people experience a lot of tension associated with sexuality in general and sexual activity specifically. When the energy of the person by a sexual intention is canalised onto the sexual realm, it takes the form of polar sexual energy; a kind of potential energy is thus build, and the enjoyment comes from this polarity.

But when reflected upon deeply, the pleasure is not a result of its release as Reich suggested, because the moment the man ejaculate (and thus accomplish his often unconscious existential goal of reproduction) and releases the accumulated sexual energy, the orgasm is over; actually most of the sexual enjoyment is immediately gone. If the man as suggested in the old tradition of tantra lets go of his intention of reproduction and therefore keeps his ejaculation back, the un-released energy will cause him to have yet another orgasm in a seemingly unlimited series (44).

Women are thus “tantric” from birth, while men have to learn it. Interestingly, many Danish women of today have a neurotic and “tense” sexuality with an unsatisfactory, extrovert, “male”, and mono-orgasmic pattern. The less emotionally tense and shameful the woman becomes during the existential or sexological therapy, the more multi-orgasmic she will become, sharing the same pattern as men: deeper relaxation means more enjoyment and deeper sexual satisfaction.

From a holistic medical perspective the tension in Reich’s sexual theory is thus more likely to be neurotic, than to be natural and healthy. Deep sexual pleasure seems to need deep relaxation, transforming the person from being in the head and mind to being centred in life and existence; the sexual experience is thus in itself salutogenic, melting the persons ego, and sending him/her into the ecstasy and sweetness of life and finally beyond that into transcendence, into the spiritual and religious realm: the loving realm of the free soul.

Interestingly, from our subjective experience, it seems that the sexual transcendence goes so deep that it even transcends the purpose of life, taking the person back to the first now of conception, before the purpose of life is decided, all the way back to the creation of the zygote from the egg and semen. Thus the fully transcendent orgasm takes the person as deep into life as theoretically possible.

Jung’s theory of sexuality claimed that every man and woman are essentially whole, carrying the opposite sex within themselves, as an “inner” man or woman, and the more natural and relaxed the person becomes, the more double-sexed will the person be. This idea or concept fits much better into the general theoretical framework of scientific holistic medicine (45-49). The sound person will always be in contact with his inner self, and

therefore also in contact with either anima or animus inside. So by nature we are, Jung said, orgasmic or double-poled beings. As a consequence of this all sexuality is in some way masturbatory, so that when we have sex, we project our inner man or woman into the partner, making this person sexually attractive to us.

This projective theory seems from an epistemological perspective extremely sound, because how can we perceive something that is not within us, as a part of our nature already? If so, the problem is the nature of this inner man or woman. Going back to the question of how biology is to be understood (34) we see, that any levels of the organism represents all other levels; the level of our totality represents the level of the cells. This gives an explanation of why it is that we on an organismic level can feel good about biological functions like eating, urinating, defecating, moving, etc. Our experience simply reflects the joy of the constituent cells.

This is what we normally call our “biological needs” (46), and these needs are something that we seemingly cannot chose to have or not have, but we can repress them to some extent, and many people have repressed their sexuality to some degree in order to be socially acceptable individuals.

Most religions have recommended people to control their behaviour connected to the biological needs, especially to sexuality, as the focus on sexuality is taking the focus away from the spiritual dimension. We have the number 666 of the beast in the bible (from the Book of Revelation of the New Testament of the Christian Bible) and we have Satan, which is opposite of God. In the Kabbalah (Jewish mysticism), the number 666 may be considered mystical and holy and may represent the physical universe. Seen theoretically this gives meaning, as the dimension of love and purpose of life arises directly from the wholeness of the person, while the joy of sexuality arises from the level of the cell. Going deeply into sexuality takes us down to earth, while going deeply into our abstract and spiritual dimension takes us all the way to meeting the totality of the world, that is into the experience of God. Fortunately these two often-conflicting perspectives can be united in one.

What is joy at the cellular level? This is an extremely difficult question; the cell is motivated for eating and reproducing, but how is this motivation organised on the global level of the cell? The most appropriate ideas from contemporary science to explain this, is a quantum field, which integrates all the molecular orbitals of the cell molecules into a true whole, and this field must then acts as a holder of information, consciousness and qualia, like pleasure on the cellular level (these speculations have been presented elsewhere (50-54)).

To conclude this paragraph, joy of being – enjoyment - arises directly from the level of the cells, fun arises from using the power of mind, feelings and body, while meaning and love arises from the global level of the human being, the totality, or soul, living its purpose of life; happiness seems thus to be a successful, balanced synthesis of fun, joy, and meaning, and a fulfilling sexual life must in the same way come from a balanced synthesis of lust, excitement and sensual enjoyment, allowing for full orgasmic potency.

Most important for sexual pleasure and orgasmic potency is the ability to relax deeply and allow our inherent double-sexed and thus ecstatic nature to manifest itself; the more our consciousness is allowed to let go of the structures of the mind and transcend, the more it can resolve itself into our fundamental biological material and we can experience our innermost and divine nature. The full and deep relaxation and the total freedom from emotional and other tensions in mind and body is thus the central aim of holistic sexological therapy.

Relevance to holistic therapy and sexology

This theory supports the intervention on the sexually dysfunctional male or female by rehabilitation of lust, excitement, sensual enjoyment and orgasmic potency. At the same time tensions, aches, pain and discomfort, often caused by the feelings from negative life events related to sex and gender should be dealt with. These tensions were at that time of the trauma repressed and placed in body and mind as blockages, specifically in the pelvis and the sexual organs and tissues (1,2,4,5,14,24,25,27).

The four standard steps of holistic existential therapy: love, trust, holding and healing are used. Holding consist of awareness, respect, care, acknowledgement and acceptance, and when it comes to sexual problems acceptance is often the most important of the five. The lack of self-acceptance is primarily felt as shame and low self-esteem. The most efficient procedure in holistic sexological therapy to solve problems with shame seems to be acceptance through touch (24).

In general sexual problems cannot be solved without a partial focus on existential issues. Many young patients will present existential problems as sexual problems, as sexual dysfunction where lack of lust and orgasmic potency is often the most noticeable subjective symptom of poor quality of life and low self-esteem.

In elder patients this pattern is reversed; often they do not expect to function sexually, but they complain of lack of lust for life in general. Often the rehabilitation of sexuality and character (21) is the path to insight in self and the purpose of life, the essence of self (16).

Relevance to sexual ethics and medical/sexological ethics

With the mapping of the three experiential dimensions of sexuality leading to the transcending experience of orgasm, it is possible to analyse what is necessary for a high sexual ethics. As most people are unaware of their most fundamental intentions, most people cannot control desire. The holistic physician uses re-parenting, that is the clear intention of being there for the patient in the same way as a good parent, as a means of controlling intention, making the intention of helping, healing and supporting the patient his/her sole focus; to accomplish this to a degree, where sexual desire and other unwanted intentions does not appear anymore is one of the signs of mastery of the holistic medical clinical practice.

As the sexual polarity is an innate quality, the sensual enjoyment connected to the mere contact with a person of the opposite sex can be diminished by repressing sexual poles (male or female); as the repression of your own gender in the clinic often will be somewhat irreversible and therefore leave a degree of permanent sexual inhibition, this strategy of controlling sexuality is damaging to sexual health, and to your character in general (21), which cannot be recommended.

Interestingly, as according to the presented sexual theory, sexual excitement comes from investing mind, emotion and body in sexuality, excitement is completely controllable. This means that instead of just controlling sexual behaviour, a person or a physician/sexologist can choose not to get sexually excited, even if the lust cannot be controlled. After some practice

sexual excitement can easily be controlled in the holistic medical clinic, making it possible to obtain extreme intimacy without getting sexually involved (25,27).

The interesting consequence of this is that sexual ethics can be taught, and we suggest that this ability of getting intimate with the opposite sex without getting sexually excited should be an obligatory part of every physician's medical training, as physical intimacy is a natural part of the job of a physician. The physician or sexologist still needs to carefully control his behaviour too, as the patient still will interpret the behaviour of the physician, and a patient should never feel sexually abused. In our experience any person, man or woman, will normally take an appreciation, when expressed verbally or non-verbally without any sexual excitement, as a compliment, while the same appreciation, when expressed with such an excitement, often will be taken as a flirt and invitation to a sexual relationship, or as a sexual harassment or even a sexual violation.

The highest degree of responsibility that a physician can take is the responsibility for the experience of the patient. In holistic existential therapy and sexology where painful old emotions are confronted and integrated, an important competence is the physician's mastery of the patient's experience, calling old painful moments into this present moment, while letting the patient clearly know and experience, that the intention of this is solely the healing of the patient.

The physician/sexologist being completely relaxed and without any sexual excitement and emotional tension, giving the patient an honest appreciation the feeling of being a well-respected, autonomous, precious and whole, is an important precondition for this kind of therapy.

Rehabilitation of existence

Working with sexual problems in the holistic clinic almost always includes existential dimensions (18). In the same way working with existential problems will almost always include some rehabilitation of gender and sexuality.

From a modern scientific perspective of holistic health, it is necessary for a person to be free and alive on all levels of his or her being, or in other words being present and optimally functioning on the axis of existence. Engaging in sexual enjoyment is a path, which connects us deeply to our life within going all the way down to the cells. As we fundamentally are a colony of cells, a sound sexuality is from a theoretical point of view also extremely important to health. This is also our statistical finding, that people who can enjoy a rich sexual life are also having a high quality of life, a good health and high ability on other areas of life (3). In holistic existential therapy it is the patient himself or herself, who deliver the material to be worked with, as the problems to be solved are the problems presented by the patients. Normally there are three steps of the rehabilitation of the patient's existence:

1. Rehabilitation of power: mind, feelings, and body – out of boredom, passivity and low self esteem (18)
2. Rehabilitation of sexuality and character (21) – out of pain and invisibility
3. Rehabilitation of self and purpose of life (16,17) – out of unhappiness and meaninglessness

Interestingly, it seems that human character cannot be fully rehabilitated without the rehabilitation of gender and sexuality, and purpose of life cannot be fully rehabilitated without the rehabilitation of the human character, and most patients have both their character and their sexuality at least somewhat repressed. This makes rehabilitation of sexuality a necessary step in the holistic medical treatment of a majority of patients to obtain a complete existential rehabilitation.

The reason for the above order of rehabilitation is quite simple: love-issues are much more painful to us than sexuality-issues, which again are much more painful to us than power-issues. This is why patients, who have had severe problems in their life (threatening their survival) often only function in one aspect of life, say mentally, emotionally or physically. A sound sexuality and ability to love will only appear after personal development and long therapy. Most people in this world are actually fixed in a mental survival position, so the normal path of development in holistic therapy with people from the western world seems to be:

- Awareness of being “in the head”
- Coming back in the body (centring in the bodies physical centre, which is often called the “hara”-centre, in the middle of the stomach five fingers below the navel)
- Opening the heart – contact with all the feelings
- Accepting the body, its organs and energy, and finally the gender: Rehabilitation of sexuality and physical character
- Discovering your true self: rehabilitation of mental and spiritual character, purpose of life, intentionality, and talents

Problems with sexuality in the clinic

Many patients are hesitant to open themselves up to this difficult area of existence and sexuality. This is because of the intense feelings of shame, guilt, worthlessness and shyness related to sex in their personal history and the societal taboo of sexuality. In the same way many physicians do not know how to work with sexuality, because of their own alienation towards their body, gender, and emotions, and are thus often unconsciously avoiding this important area of existence. To avoid working with sexuality in holistic medicine might be harmful for the patient, as the progress of the patient is easily arrested at level 4 in the above list of steps. This is still far from the healthy position of being able to love yourself and others, and far from knowing and living the purpose of life.

It is therefore of great importance that the holistic physician is able and well functioning in all aspects of sexuality in order to help the patient to confront any problem in this sensitive area in order to heal. The intimate re-parenting that is needed in much holistic therapy demands, that the holistic physician is keenly aware of the border between intimacy and sexuality, to be able to be completely intimate with the patient, without getting into a sexual relationship (like flirting, circulating sexual energy, having sexual behaviour etc.). As sexuality starts with the intent, it is only a question of training the physician to be able to be intimate without having a sexual relationship; the solution is that the physician at all times is aware of his or her own intent, to keep the healing of the patient as the only intent during the

treatment. The physician must strictly avoid all kinds of behaviour, like flirting, which can be misunderstood as a sexual intention. As all physicians know that it is unethical to abuse their patients, and most physicians comply to the ethical roles of their community, complains from a patient about sexual harassment or sexual abuse often comes about with the physician not sufficiently understanding the sensitiveness of this issue, and the patient's transference during the therapy. Unfortunately there still are a large number of patients, who actually experience violation by their therapist, as for example in one survey which showed that 23% of incest patients reported they were violated by their therapist (55) (including both physicians and non-physicians). What happens when an incest victim is experiencing this is not entirely clear; a logic possibility is that they project the original perpetrator on the therapist. The better the sexologist can define his own sexual borders the more difficult it is for the patient to project the perpetrator on him. Training of the sexologist is therefore extremely important in order for him to develop the ability to keep the sexual border, while being intimate emotionally with the patient in the process of healing.

This leads to another extremely important principal question, the fundamental ethical question related to sex: when is a sexual experience good and harmless, when is it healing and developing the person, and when is it damaging to the person?

Although the issue of sexual ethics has received more attention in medicine than any other ethical issue and in traditional medicine the ethical rule regarding sexuality is quite simple: do not engage in any sexual relationship with the patient. In holistic health care this simple rule is more relevant than ever; but as sexuality is often much more subtle and much more present in the holistic therapies – i.e. in psychotherapy and in bodywork - the issue of sexual ethics needs more clarification. The first researcher to struggle with the problem of how to deal with sexuality in the holistic clinical setting was Sigmund Freud (1856-1939), who in his famous paper "Transference love" gave his clever advice to his fellow psychoanalysts (56):

"It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these; it is one for which there is no model in real life. He must take care not to steer away from the transference-love, or to repulse it or to make it distasteful to the patient; but he must just as resolutely withhold any response to it [i.e. avoid acting out]. He must keep firm hold of the transference-love, but treat it as something unreal, as a situation which has to be gone through in the treatment and traced back to its unconscious origins and which must assist in bringing all that is most deeply hidden in the patient's erotic life into her consciousness and therefore under her control. The more plainly the analyst lets it be seen that he is proof against every temptation, the more readily will he be able to extract from the situation its analytical content. The patient, whose sexual repression is of course not yet removed but merely pushed into the background, will then feel safe enough to allow all her preconditions for loving, all the fantasies of her state of being in love, to come to light; and from these she will herself open the way to the infantile roots of her love."

Freud became famous for his realisation of the importance for the patient's health by healing her sexuality. He had also realised that while working on releasing the patient's sexuality from suppression, the female patient frequently felt in love with her male therapist and he also noticed that this transferred love could reach extreme intensity. Most disturbingly Freud also

noticed the impact of the transference-love on the therapist, since it often gave a strong sexual counter-transference as an involuntary response.

This was a serious problem to psychoanalysis in its early days. Freud had two main concerns here: How could the therapy continue in spite of the seemingly locked situation, where therapy turned into a love affair? And how could the therapist help himself to avoid getting sexually involved with his patient? Freud ingeniously realised that the mutual sexual attraction was unavoidable in the psychodynamic therapy and he also realised that it was a most useful artefact, if the therapist had a sound response to the sexual interest of his female patient. Freud's solution was that the therapist's reaction should neither be so cold that her sexuality was re-repressed, or so hot that it resulted in acting out on the sexual desire.

On one hand, the therapist should give his full acceptance to every aspect of his patient's sexuality and also actively encourage the patient to go deeper into it; and on the other hand the therapist had to completely resist the temptation of a sexually interested woman totally in his power. The therapy should be done in a loving, accepting and caring way. Freud always advocated honesty with his patients in analysis. In this case honesty would mean the therapist letting his patient know that he also felt attracted, but that he managed to firmly resist any temptation. Since 1912 this well-tempered response has been the solution to this severe therapeutic headache. With this said, the complexity of the matter must be underlined: In the above mentioned paper Freud recommended a "neutral" response to the patients sexual interest; it is not so clear from Freud's writings how such a response really looks, and how sexual "neutrality" goes along with honesty in the case of a strong sexual counter-transference.

Holistic health practitioners are often dealing with patients that are chronically ill with no improvement from standard treatment, including psychiatric and sexological treatment. Today's intensive holistic therapy with these patients often include bodywork and here every kind of sexual reactions are found, from the patient entering catharsis from remembering early sexual abuse – and sometimes even projecting the abuser on the therapist to avoid the emotional pain of the traumas - to the patient re-discovering her own sexuality in the therapy by sometimes having "unprovoked" orgasms, which happens suddenly, uncontrolled, and without any warning, often resulting from only a light touch on the patients non-erogenous zones of the arms or back. The enhanced difficulties of sexual transference, when working directly on the body makes the discovery of Freud's solution more actual than ever, and every student of holistic therapy must be trained to have a firm, proper and constructive, therapeutic response to the patient's transference of love.

It is important to remember that what happens in the therapy must always be done with the full consent of the patient. There are very different views on the value and significance of a patient consent in different countries and cultures. In Denmark, which value patient-autonomy and very liberal when it comes to sexual issues, the patient consent is what makes a medical procedure legal and acceptable. In many countries outside Denmark the mere suspicion that consent to a procedure has been given under the influence of transference would weaken the significance of the consent and raise suspicion of the patient being exploited by the therapist.

In therapy it is very important to facilitate the patient's re-experience of traumatic life events emotionally in order to enter the state of existential healing (salutogenesis) by use of the famous "principle of similarity" (57-63). Since Hippocrates it has been of crucial importance that the patient is never harmed, and this is even more important for the holistic

practitioner today. It is also necessary that the holistic therapist always respect the laws of the country. National laws might set severe limits for what can be done in the holistic clinic, even with the presence of both a written and an oral consent of the patient, and the holistic practitioner must be continually engaged in awakening the public awareness of any need of changes of the actual laws, in the best interest of his patients.

Explaining sexual difficulties and abnormal sexual behaviour

The lack of one of these three: lust, excitement and pleasure/orgasm, or the presence of the opposite of pleasure, which is pain, are traditionally described as the most common sexual problems, together with the emotional problems of anger, hate, shame, guilt, disgust, helplessness and other difficult feelings. Vaginismus (40), vulvodynia (41) and other sexual dysfunctions seems to be caused by the repression of such feelings into the body and its organs and tissues, and these problems are normally solved, when the old, painful emotions are processed and integrated during holistic existential therapy or holistic sexological therapy (40-43). Repression is according to the life mission theory (16-22) a consequence of negative decisions taken in emotionally difficult moments (called gestalts) to escape the responsibility and thus repressing the emotional and existential pain. Sexual problems respond to holistic existential therapy addressing the negative decisions, and many different problems can be solved using this kind of therapy.

Vaginismus, vulvodynia, impotence

Vaginismus (tightening of the vagina during or before having sex) and vulvodynia (chronic pain in the vulva without a physical cause) are in our clinical experience almost always caused by repressed emotions like shame, guilt, disgust, and helplessness connected to earlier sexual experiences; the proof of that being the fact that most of the patients can be cured by the simple procedure of acceptance through touch (24). Impotence can be caused by physical defects in the penis; much more often the reason is lack of lust, excitement and pleasure/orgasmic potency; the cause according to the present theory is the repression of the patient's sexuality by negative decisions throughout life. Holistic existential therapy therefore can rehabilitate potency in most cases without biological tissue damage. Temple goddesses has seemingly had this function in India for millenniums, but the first scientific attempt of this kind was made by Masters and Johnson (1,2) using substitute partners in the middle of the 20th century, and most of the dysfunctional males could be cured in only fourteen days.

Adultery and use of prostitutes

Most people of the west acquire early in life a sex-love split, which seemingly makes it almost impossible for them to be fully satisfied sexually with the person they love (see discussion below on the healing of this split). This split is caused by the reorganisation of the

life energy of the organism in several separate circuits, to protect the person from being destroyed by rejection from the opposite sex (mother/father). Adultery and the use of prostitutes are thus a normal behavioural pattern, unfortunately often harmful, but difficult to regulate by law. The sex-love split is also a reason for therapist's to have sex with their patients. The healing of the sex-love split of the therapist is thus a precondition for the ability to manage your own sexuality and respect the sexual borders of the patient and only a whole therapist can sufficiently help the split patient to heal in the sexological clinic.

Pornography and lack of satisfactory sexual partners and orgasmic potency

The market for pornography has exploded through the last decades as most people in the west have now accepted pornography and many normal people use it for sexual stimulation. The market for internet pornography is said to grow at an astonishing rate of 100% each three month. The reason for this need is either a lack of a sufficient sexual partner or an obvious lack of orgasmic potency, making the normal sex boring and unsatisfactory. When the natural faculties of lust, excitement and orgasm are rehabilitated, the need for artificial stimulation like pornography disappears. The problem of getting a sexual partner will normally also disappear with this rehabilitation, as the sexually attractive woman is a woman who likes sex, and the sexually attractive man is a man who can relax in his contact with the female energy.

Homosexuality

One percent of the Danish population is homosexual (3,64). A complete theory of sexuality will also solve the mystery of homosexuality, which cannot be an effective biological strategy of survival. Freud had his spacious idea about the child being polymorph perverted, and homosexuality rising from the child not learning to turn sexuality towards the genitals of the opposite sex. Our understanding is in line with this view: sexuality is directed by intention; therefore a person can choose – consciously or subconsciously - to direct his/her sexuality towards any gender or any item for that sake. The reason for choosing homosexuality could be neurotic; in this case a normal sexual flow of energy and interest is for some reason blocked, and homosexuality seems to be a possible solution to a hard existential problem: how to relate satisfactory to the other sex. We have seen women in the clinic who turn lesbian after rape in childhood, and who turn straight when this trauma was integrated, in support of such a possibility. In theory homosexuality could also be a genetic determination, but judged from our clinical findings we find this possibility to be more unlikely. According to the present theory homosexuality will be reversed to heterosexuality, if the person let go of his/her decisions of projecting sexuality towards the same sex. According to our clinical experience decisions causing homosexuality can be a product of sexual abuse, like one of our clients, who presented as a lesbian, but during therapy it was revealed that four older boys raped her repeatedly at the age of 4 to 8 years, which changed her object of sexuality.

Incest

Members of the family almost always inherit the sexual pattern of incest via sexual abuse of the violator. The best cure is taking the whole family into therapy, which can be extremely difficult, because of the intense emotions connected to the severe taboo of incest. Years of holistic existential therapy and holistic sexological therapy are often needed for the incest victim for a full rehabilitation of self-esteem, ability to feel, and sexual health (65). The position of Freud was here again spacious, claiming in the theory of the Electra/Oedipus complex that all small girls have sexual fantasies about her father, and vice versa the boys.

Paedophilia and child pornography

The simplest way to understand paedophilia is to look at it as an arrested psychosexual development, the person sexually attracted to children being of the same developmental age as the desired child. The only cure for this is to facilitate the sexual development and maturation of the paedophile patient. Feelings like shame and guilt, disgust and hopelessness/helplessness are most likely to appear in the therapy, often caused by sexual violation of the person, when he/she was a child of that age him/herself. This kind of paedophilia are always friendly, kind, peaceful and seeking the full acceptance from the child, as if the patient him/herself had the age of the violated child.

A more twisted and violent version of paedophilia is when the patient has lust for inducing pain, fear, shame, guilt, disgust or other negative emotions in the child victim for sadistic sexual pleasure. This behaviour comes from the patient subconsciously choosing to be evil (20), and is often disguised as a tendency to justify punishing children. This dark pattern often reflects the violent nature of the patient's own traumas. According to the theory of the evil side of man (20), this kind of behaviour can even in an more evil version be a direct consequence of a conscious choice to do evil (see "rape" and "sexual torture" below). The way to treat this is to let the patient be as evil as possible in the therapeutic session, and then confronting him/her with the good (the light), the therapist coming from deep and unconditional love for this tormented soul. Of course this kind of holistic existential therapy can only be practiced, if the therapist can truly love his patient, which can be very difficult with patients suffering from this kind of severe pathology.

Rape and sado-masochism

The phantasm of rape is common with both sexes, woman often dream of being raped and men about raping. The logic of this is clear, when the nature of the masculine and the feminine sexuality is taken into consideration. The male urge is to spread his genes in all directions, and the feminine urge is carefully to select the best genes for her offspring. The strongest, healthiest or most intelligent male must be preferred and this is the man she cannot in the end resist sexually, so she must melt, give up her resistance and receive him. And vice versa: this woman is forced to acknowledge his sovereignty and therefore she finally melts into his strong arms and finally surrenders and give her body to him. Unfortunately this

simple sexual scheme that in dreams and fantasies is the most natural thing can almost never be realized in the form of rape with a pleasurable feeling and good outcome for the woman. Rape and violent sexual domination often leads to severe traumatisation of the woman, and also often of the involved man, who never intended to do her any harm.

Men who rape are often simpleminded and severely damaged existentially. They are often poorly integrated in the culture and society they live in. In principle they can be helped by holistic existential therapy to get a meaningful and emotionally satisfying relationship with a woman. In principle it could be done if the perpetrator understands the need of existential rehabilitation and an expert therapist, who must be able to truly love them as souls and accept them exactly the way they are. The game of sado-masochism is very popular in most large western cities, but the effect of this in sexual health is not clear.

Sexual torture and sexual murder

Snuff pornography where girls are raped, abused and even killed are on the market. We are posing the question why sexual violence has pornographic value. The explanation is likely to be that many people carry an intense hate towards the other sex linked to the gender, because of neglect or violation from the parent of the opposite sex. Many patients experience, in holistic therapy with spontaneous regression to the age of one, two, or three years of age, that they actually wanted to kill their mother or father, because of very painful early events with violating or emotionally dissatisfactory interaction. The intensity of emotions of small children reappearing in the therapy is really overwhelming (as described by Janov in his book on the primal scream (66)), and the intentions of the small children reacting in an attempt to survive the experience are often extremely evil, although they do not have the power to materialise them at that age.

After 20 or 30 years, the person has become an adult in full power, but fortunately a normal person will have matured and in this development he/she has released the immature and childish evil intentions. If the person has been arrested in the psychosocial development, the evil intentions can be intact, and now materialised with the full adult power. This is the scary scenario of destructive rape, sexual torture and sexual murder. Many sexually repressed people carry in their dark side such evil sexual fantasies, which are seldom shared, not even with their therapist after many years of therapy. The degree of trust it takes to open up for an honest conversation on these matters is extreme; therefore these people live amongst us without anybody knowing what kinds of dark secrets they carry. And without the integration of the dark side, the patient will forever remain sick in his/her soul, and potentially a sexual violator the day a possibility opens up.

Intimacy, love and trust is the only road to healing the existence and the only way to prevent such evil deeds. If a patient reveals an interest for evil rape or snuff porn or murdering woman in his sexual fantasy or similar matters, this must be taken as a serious problem in the therapy, and the patients must, if possible at all, accept to work with and process the original traumas giving birth to the evil sexual intent.

Discussion

As every human life starts as a unification of the egg and the sperm, it seems that this fundamental set up with two poles, a male and a female, is at the root of all human life. From the beginning we are sexual beings and all the fundamental driving forces in life seems to be of a similar energetically structure, the two poles are always there, when a movement is done or a change is wanted. The highly abstract nature of the two poles makes it problematic for us to understand sexuality.

Sometimes, when we want to make a difference through time in society or in business, we do not conceive such an endeavour as sexually motivated, but deep down it is about power, and all power is conceived and motivated by the fundamental driving force in our life, which in its essential form is bodily and sexual. Freud called it “sublimation” of sexuality into the mental and intellectual area. Aldous Huxley (1894-1963, an English writer) is told to have said that “an intellectual is someone who have found something more interesting in life than sex”, and in a certain way this is absolutely true, because wanting sexual intercourse is only the most physical and the most concrete presentation of the sexual polarisation in our life. The closer we come to grasping the abstract and all including concept on living with and carried by to two fundamental poles, the more powerful we are in our own experience and the stronger is our impact on our close and distant world.

Power and excitement is fundamentally about finding this polarity within ourselves and taking it into use as cleanly and focused as we can. Interestingly sex and power are often seen as dirty in our culture and condemned, but in our culture it seems that we use a lot of energy to control others and ourselves. The motivation of this repression of sexuality is found early in life, as we need to repress our own sexuality to the same degree as sexual repression that exists in our family in and between our parents. This down adjustment of our own fundamental power seems to start already in embryonic life, judged from the experience of being extremely sexual that often follows therapeutic regression late in the holistic existential therapy, where the patients often go all the way back to the early foetal periods (the first weeks after conception).

This is a complex situation difficult to understand, when two abstract poles are our life's fundamental motivational force, driving all the sexual, emotional and psychic energy of our life. Many layers of adaptation have lead to repression of so many different aspects of bodily, sexual, emotional, mental and spiritual functions. Actually these repressions are the backbone of our personality (ego), and only by letting go of the negative decisions are we able to repress these aspects of our true self and return to our true human nature.

Holistic existential therapy is therefore, as psychoanalysis and Jungian therapy, highly focused on supporting the patient in finding these two abstract inherent sexual poles, setting them free for use on all levels from sexuality to brainwork and spirituality in the human being.

That the nature of the poles is abstract means that the poles are bound to our totality, our wholeness. The way the poles are held by the cell is determining the whole motivational and energetic set-up of the organism, so let us explore this difficult and unclear issue. We start as two cells fusing into one cell and just before conception the poles are the creative force making the embryo. When it is created the two cells are gone and one remains, carrying the two poles within it on an abstract level. If we accept the idea that the cell remembers the

fertilized egg and will remember its creation from two cellular poles, as there is no structural evidence of the egg being a double being, the polarity is seemingly internalised. How is this done? One obvious answer is through the memory itself. Interestingly the embryo as a gender, making only one of the sexes manifests in its own biology, and in the beginning there is no known structures making any sexual discrimination. The zygote is thus with regards to energy and information both male and female, except for a tiny chromosomal difference to be expressed much later in the morphogenesis, when the embryo finally expresses one sex.

So early in foetal life, it seems that the organism holds the sexual poles in its wholeness, in what we call the conscious or “spiritual” level of the organism. How is this done? Well, how is consciousness and wholeness organised in the zygote, and in the cell in general? The most fundamental aspect seems to be through wholeness, giving the light of consciousness, and through representation of the inner and the outer, that is memory and perception, giving the content of consciousness. In order to understand that, we have to realize that the cell is a part of the web of life, the coherent matrix of energy and information that all life is a part of (22). The cell is part of the flow of life, the flux of energy and information is running through it and it contains its history as a personal memory to be used through life. Where are the sexual poles? They are represented in the consciousness of the cell through personal memory and also the web of life, having built the poles into all life, represents this set-up.

While the foetus expresses only its one gender physically, the other is still there on the abstract level, in the wholeness and in the memory, and in the web to be used by the organism in sex, an intellectual endeavour etc. Thus we are energetically two-poled beings. The sound sexuality is built around a circuit of sexual energy running within each individual integrating the manifest gender and the opposite only manifest in consciousness; sex is in a way masturbatory as pointed out by Osho (67), and all sex is about aligning the two separate sexual circuits of the two lowers. When this is done the other represents the inner man and the inner woman of the counterpart. Being in love is often highly projective, and the projections often binds the sexual energy and locks it in neurotic patterns and thus becomes a hindrance to the natural and sound experience of desire, sexual excitement, pleasure and orgasm.

Healing the sex-love split: A challenge for every man and woman

Interestingly, we are also one-poled beings, in that love creates unity, within us and with other people around us. The most fundamental problem in adult life is how to deal with both love and sexuality at the same time. Love brings closeness and unity; sexuality needs distance and polarity. Love is a surrender, abstaining from all power and all conditions in the service of the other, while what turns sex on in us is about meeting the unknown, dominating or being dominated, closing a distance between us, being separate beings. The relationships with our mother and father were so loving and close by nature that sexuality had no place in it. First in adolescence, when the child separates, starts the sexual play so crucial for psychosexual development. In the lack of intimacy, the relationship between parent and child can turn sexual, leading to the problem of incest, severe psychosexual development disturbances and pain with repression and condemnation of sex and lust, nymphomania (personal value connected psychologically to sexual attention) among others.

The sound sexuality is integrated in human life, so the love, the strength and the gender and sexuality are aligned in the person, and sexuality becomes an expression of physical love. When two whole people have sex they come from everything in themselves and accept that. This sound sexuality is unfortunately a rare and highly advanced human state. Every man and woman on planet Earth needs to heal his/her own sexuality, and for this project we urgently need physicians who are able to assist the population in this area.

On the positive side of all the sad things related to dysfunctional sexuality is the paradoxal posttraumatic growth, seen after rape and other violations. This important phenomenon reminds us that not all is lost, even after the worst case of abuse and pain, if we understand to help the victim to learn what happened and develop as a person. Fine therapy can apparently compensate for the harm of even evil trauma (68-74).

Conclusion

The present theory describes three dimensions of sexuality: 1) desire, 2) excitement, and 3) sensual enjoyment and when combining these three, transcending into orgasm. The theory also describes the inverse experience in sexual pain, disgust and humiliation.

The most common sexual problems, like impotency and anorgasmia, can be understood as the lack of one or more of these three positive elements, or as presence of the negative dimension of pleasure, which is pain (intentional failure, emotional frustration or physical pain). The reason for lack of desire, excitement or pleasure is the specific repression of the corresponding dimension of sexuality, or the general repression of the patient's purpose of life, gender and personal character, and general power of mind, feelings and body.

Other problems like premature ejaculation, vulvodynia and vaginismus are caused by repression of the emotional problems of shame, guilt, disgust, helplessness connected to sex, vulvodynia and other dysfunctions seems to be caused by the repression of such emotions, and these problems are normally solved when the old, painful emotions are processed and integrated during holistic existential therapy or holistic sexual therapy.

Full orgasmic potency is the ability to obtain desire, excitement and sensual pleasure culminating in a peak (peak orgasm), which can be prolonged into a plateau of intensity (silent ecstasy/plateau orgasm), repeated into the multi-orgasmic experience, and finally expanded from the genitals to an all-including, transcending experience.

The three dimensions of sexuality fits into the theory of talent, in the way that lust arises from intention, excitement from personal power, and orgasm from the dimension of gender and sensual enjoyment. Accordingly, the ability to have the full desire and full control of excitement and behaviour is rehabilitated together with the ability to know and be your true self. The ability to get a high level of excitement is rehabilitated when full personal power is rehabilitated, and orgasmic potency is rehabilitated when the ability to enjoy fully is rehabilitated.

This theory predicts that holistic sexology or holistic existential therapy can rehabilitate many cases of sexual dysfunctions, including vulvodynia, vaginismus, impotency, and tendency to rape, child abuse, and other sexual violence.

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Genital, sexual and non-sexual pain and other health problems related to the female gender

The many different health issues related to the vulva requires an interdisciplinary and holistic approach, as medical, psychological, sexological and existential aspects are intimately interwoven. Vulval problems are often chronic and the patients have had them for many years. In this chapter we suggest holistic sexology to be an important intervention for a long series of vulval health problems. We argue that the vulva carries immense symbolic meaning making it a focus point in the body of the most difficult feelings and emotions, making the vulva more exposed to psychosomatic problems than any other organ of the body. We recommend as an important tool what have been called “clinical medicine” - curing the patient through the growth of self-insight coming from the physicians and the patient’s common exploration and investigation into her life, body, gender, sexuality, and feelings associated to her inner and outer genitals. A surprisingly number of different diseases and disorders can be cured in this simple way: Vaginal infections (non-STDs), skin problems such as lichen sclerosus, lichen planus, and lichen simplex chronicus, vulvovaginitis /inflammation/chronic infection/vaginosis of the vulva and vagina, chronic pain, (burning, irritation, pruritus), vulvodynia and pelvic pain syndromes, sterile and non-sterile urinary tract inflammations, PMS, amenorrhea, and sexological dysfunctions including sexual aversion syndrome and psychosexual developmental disturbances, lack of genital self esteem. NNT=2 estimated from the literature. Tools are talk therapy and therapeutic touch including five tools of holistic manual sexology i.e. including the sexological examination. Finally the ethics of the vulva clinic is discussed.

Introduction

The vulva clinic has a long and complicated history with a large number of unclear and overlapping diagnoses (1). There are problems related to sexuality, like dyspareunia, which

are closely related to the sexual dysfunctions, like lack of desire and excitement, anorgasmia, sexual aversion disorder and low genital self esteem.

There are also problems not related to the dynamics of coitus or the psychosomatic and psychosocial aspects of sexuality like chronic infections (vulvitis, vaginitis, vaginosis, STDs), chronic sterile inflammations (vulvar vestibulitis syndrome (VVS)), irritated clitoral prepuce, and more, and pain for no “anatomical” reason, like vulvodynia (vulvar pain with no visible organic cause), dysplasia (Lichen Simplex Chronicus, Lichen Sclerosis, and Lichen Planus) and vulval cancer. These clinical conditions are often in the biomedical clinic seen as more “organic” and of less psychosocial origin.

There are the problems related to the muscles of the pelvis (the pelvis floor, the deep (long) skeletal muscles) and the diagnoses associated with this (pelvic pain syndrome, possibly also vaginismus etc). Finally there are referred pains and discomforts from the low back, uterus, uterine ligaments, intestines, kidney, bladder, urethra etc. On top of this we have a whole class of somatisation, hysteric, and hypochondriac mental states often involving the vulva, vagina, uterus, ovaries, anus etc. Often the woman fears to have cancer although vulval cancers are rare.

The pains are a study in itself. There are deep pains and superficial pains, pains associated with the mucosa and pains associated to the muscles, there are provoked pains as in dyspareunia, and non-provoked constant pains as in most cases of vulvodynia; there are allodynia where a light pressure from a cotton bud (Q-tip) provokes the pain, and then there are wandering pains that shows up here and then another place, and there are infrequent pains that only comes sometimes. Then there are sharp cutting pains, there are itches and discomfort going all the way to psychological factors like low genital self-esteem and even strong shame, disgust, and repulsions connected to own genitals, the last often somatisating into one of the other types of pain and discomfort.

When it comes to the objective findings from the pelvic examinations there is a similar spectrum of infections, vaginoses, variations of flours, inflammations, and unspecified irritation and visual redness, mucosal thinning, and then again very often nothing pathological to see at all, or a pathological finding not at all explaining the reported symptoms. The explorative phase often reveal some tenderness, and if you are lucky the exact pain or feeling that the patient complains about.

Often there is a strong emotional reaction to the pelvic exam that is known to be stronger if the patient has been sexually traumatized or abused. The whole abuse aspect is a complicated thing in itself, incest and sexual abuse being extremely common, as it often has been found in population surveys that at least 15% of the girls of the western world have been sexually abused.

If you use the ISD-10 or DSM-IV-TR you will end categorizing your patient in one of the categories of the system and treat her accordingly, but little is known about the effects of the treatments, as there has been very few controlled clinical studies in the vulva clinic. At Columbia Presbyterian Medical Center Cutaneous-Vulvar Service the most common presenting condition was diagnosed as vulvar vestibulitis (36.2%), followed by lichen sclerosus (19.2%) and vaginitis/vaginosis (14.8%) (1).

In general the most common diagnoses related to vulvar pain are vaginitis/vaginosis, vulvar vestibulitis syndrome (VVS), dysplasia (Lichen Simplex Chronicus, Lichen Sclerosis, and Lichen Planus), and vulvodynia. It is known from many population surveys now that the prevalence for vulvodynia is about 10% of young women, but most of these women are not

seeking medical attention as it is generally known that there is no efficient cure; surgical vestibulectomy seems only to give temporary pain relief, and it has almost always serious side effects and active pharmaceutical substances often do more harm than benefit.

In general the vulva clinic has been rather inefficient in understanding and healing the patients' many and complex disorders and discomforts. Recently the traditional diagnosis has been challenged, and most of the commonly used treatments have been found not to be evidence-based. We obviously need a much more integrative and holistic approach to the vulva clinic.

The holistic vulva clinic

The traditional medical and gynecological approach to the vulva clinic is the pelvic examination and in the sexological clinic this is complemented with the sexological examination (2-7). In holistic medicine and sexology the focus is not the vulva, however obvious since the symptoms come from here, but always the whole person, and her body, mind, spirit and heart (existence).

If you are a busy physician just this last sentence will already have spoiled your motivation for further reading of this chapter. But this is a fact: The vulva has no life on its own, it is a completely integrated part of the woman, and from a holistic medical perspective all vulval problems, except the most banal STDs (and maybe even these), are a materialization of the women's problems with body, gender, and sexuality.

Even dysplasia and cancer, except for a few genetic cases, are from a holistic perspective often directly caused by the inner imbalances and disturbances in the biological information system that normally guides the cells to do what needs to be done in the body, including the genitals, in an orderly way. If this biological order is disturbed the cells start dividing randomly and without respect for the order of the tissue they come from, which is cancer per definition.

The genitals are a focus point of the strongest emotions and feeling in a person's life; the female genitals are psychosomatically burdened by representing the woman's ability to reproduce and her sexual attractiveness.

We doubt that any woman honestly can say that they never have felt sexually violated at some point in time. Most girls are not allowed to have the natural sexuality they are given by birth, all this giving the experience of sexuality a negative colour (8). The fundamental idea of holistic medicine is that the tissues of the relevant organs hold on to the emotional pain (and joy) that cannot be accepted, contained, and integrated as natural part of life. All these repressed feelings are then disturbing the biological order.

As vulval health issues are closely connected to the personal history of sexual traumas and sexual repression, the fundamental tool of the vulval clinic is what has been called "clinical medicine": The examination and exploration of the problem and its causes together with the patient (9).

Understanding is the cure. Insight is what heals. Even cancer is from a psychosomatic point of view likely to be a materialization of chronic irritation and discomfort (10-16), so this approach might even cure vulval dysplasia and cancer (most unfortunately we still miss good clinical trials to see if the holistic approach is more effective in making the patient survive

that surgery and chemotherapy, but there can be little doubt that most women would like to keep their vulva intact if possible at all).

So the holistic cure in general, not only to vulval and genital problems, but to all health problems, is the exploration of the patient's body, emotions and feelings, mind, spirit, heart and whole existence together with the patient. There are basically two tools here, which are talk and touch (17-19). The combination of talking and therapeutic touching has been found to be the most efficient kind of CAM often called "mind-body medicine" (20).

Mind body medicine and CAM is known not to have any significant side effects (21-26), meaning that you can safely use these tools without worrying about harming your patient (the opposite situation of using drugs and surgery, where you most often induce some kind of side effect and harm).

Most interestingly is it that mind-body medicine has been found highly efficient for a long series of clinical conditions, like coronary heart disease (27,28), cancer (29), and somatic and psychiatric problems (30-35); we find it likely that all kinds of infections, inflammation, chronic pains, autoimmune disorders, and a long row of psychosomatic disorders can be cured this way, as it has been for millennia (36).

There is still too little knowledge about the efficacy of clinical medicine for each concrete disorder, including the vulval health issues, but in general research has shown that every second chronic patient with somatic, mental, sexual and existential problems can be cured in only one year with about 20 sessions. If therapy is continued another 25% (estimated) will be cured the next, in the end curing most patients. We therefore have reason to believe that holistic, clinical medicine is the most efficient type of medicine there is, also for the vulval disorders.

The practical approach

The first thing to realize, which might be pretty hard for a busy physician, is that the vulva does not live its own life; it is a part of a woman with a precious often severely wounded sexuality, and the vulva is, as her primary sexual organ, a materialization of the state of her sexuality and life energy as such.

The vulva is therefore an organ loaded with strong and often difficult emotions, feelings and sensations, and the mere approximation to the vulva as you are going to examine it, will provoke a strong emotional reaction in your patient that will tell you more than a thousand words about the reason for her vulval problems.

Never miss the opportunity to open the conversation about relevant feelings and emotions at this point. It might be emotionally difficult for both of you, as it opens up to the woman's most intimate and private secretes of her life, so be gentle, compassionate and empathic. Kindness is an exquisite art, and healers need to masters it impeccably.

From a holistic perspective, a compromised immune system locally in the vulva, a dysplasia of the mucosa, a strong irritation of the introitus, or a strong pain provoked by a touch of the deep skeletal muscles have pretty much the same cause, which is an disturbance in the pelvic area of the biological information guiding the cells and tissue.

In our experience such an informational disturbance is almost always caused by emotional problems related to her sexuality, i.e. strong positive and negative feelings and

emotions that have been repressed long time ago as her childhood environment, most often both her parents, could not accept and contain her childhood sexuality. Naturally sexual abuse and self-abuse, i.e. from having sex without feeling desire and excitement, but only from a felt obligation to the man, which is extremely common, can have made everything much worse since then.

So basically, from a holistic point of view, we as physicians and therapists are sitting next to a person that has a vulval problem caused by the woman not being able to experience, contain, express, and live her sexuality freely. The idea is that if you are able to help her understand herself and return to normal sexual functioning, all her vulval problem are most likely to disappear.

So only when she is sexually healed and only when the emotional scars on body and soul causing the vulval disorder are healed, will her vulval symptoms disappear. To physicians not acquainted with psychodynamic or holistic-medical theory this might seem farfetched, but let us assure you that it is not. Many of the old physicians, and even Freud, Jung, Reich, Lowen and so many more of the greatest healers and therapists of our time have carried that conviction: The blockage of sexuality is the primary cause of physical and mental disorders, as sexuality is our primary life force. And nowhere is this psychosomatic connection seen more clearly than in the vulva clinic.

The sexological approach to vulval problems is not new of course; it has been used ever since Hippocrates invented the pelvic massage (often called “physical therapy for the pelvic floor”) as cure for hysteria and other disorders of the female (36). What the Hippocratic doctors did was very simple: Massaging the genitals and other organs of the pelvis, until the emotional resistance was resolved; the female patient healed emotionally and existentially in this process and developed eventually her mature, genital character (37,38).

In the sexological clinic Wilhelm Reich and other holistic sexologists developed the concept of working against the patient’s resistance to perfection (39). To work against the emotional resistance basically means to give her full emotional support and at the same time, for the sake of healing, expose the patient for exactly what she likes the least. Doing this is to use the classical Hippocratic principle for inducing healing called the principle of similarity (40-46). The principle of similarity means that you are behaving caring to the patient and in the same time, but in good intent, evil to her, to helping her re-experience and feel the original difficulty that lead to the repressed feelings that now causes her illness.

To use the principle of similarity in clinical medicine is quite an art; first you must win the full confidence of your patient, and then you must explore in a playful experimenting way what is going on inside of her. Actually you do not only need to be kind and caring, you need to be as supportive as a good parent - that is in essence *loving*.

You need to be a generous and loving person to be a great doctor. As very few medical doctors are relaxed, easygoing and loving people; practicing clinical medicine takes a great deal of personal development and also coaching. As you practice it you will learn as much about yourself as you learn about you patient. This process always takes some assistance from a supervisor or therapist where you can explore yourself, your own feelings, you own sexual reactions etc. Only when you truly know yourself you will be able to follow your patient relaxed and confident into her most shadow sides.

Most physicians do not like the concept of clinical medicine where the examination is the cure, because they are also touched, provoked and in the end cured by this procedure; holistic medicine might seem really strange for the biomedically trained physician and starting with

the whole person ending with the sick organ is quite the opposite of the normal biomedical procedure in the gynecological clinic where examination, diagnosing from the local findings, and treatment of the specific organ's disorder is the standard practice.

So, to come back to the essence of the situation: You are in the holistic vulva clinic sitting with a patient, a woman, who has a problem with her genitals, because she has a problem with her sexuality, because she was treated without love and acceptance of her body and sexuality in her childhood, or because she had some kind of disaster like a sexual violation or a relationship with self-abuse in her teens. If you support her to the deep insight and self-acceptance that she is missing today, she is most likely to heal her sexuality today and her vulva tomorrow.

The three steps

One of the most powerful, traditional tools in sexology that is relevant in the vulval clinic when the female patient needs to explore and investigate her sexuality and return to normal sexual function of the genitals, is *the educational gynecological sexological examination*, often just called the *sexological examination* (2-6).

To use this tool you need to have a good training in therapeutic touch and a comprehensive understanding of female sexuality and the way it is manifested in and expressed through the female genitals. If you are a male you need to support your female patient on the energetic level meeting her with your masculinity; if you are a woman you need to come from your inner male to give your female patient the appreciation and emotional support she needs to go through this challenging procedure.

We recommend that you are familiar with the literature on sexology and with psychodynamic theory, especially the works of Freud, Jung, Reich, and Searles (47). You also need to be well trained on bodywork; good systems are Reichian therapy, the Rosen Method, bioenergetics (Lowen) (48) and similar mind-body techniques.

We recommend that you complete training as a body worker and also take sufficient training in sexology; the European master of science of complementary, integrative and psychosocial health sciences (EU-MSc-CAM) is recommended if you live in Europe (40-47). On the other hand, if you always have worked with body work and sexuality, and enjoy a happy sexual life with your partner, and have a high quality of life and a good life in every way yourself, you are most likely also to be a good doctor or sexologist, and then you do not really need more training. Still you need a supervisor and we strongly recommend that you read the practical ethical recommendations for holistic physicians, therapists and sexologists as they are formulated by the International Society for Holistic Health (49). We also recommend the therapist to be member of a Balint group.

After these introductory remarks on qualifications, let us proceed to the procedure. There are basically three steps in the sexological examination: Recollection of her personal sexual history, visual examination of her genitals together with her, and exploration of vulva/vagina/anus to support her in exploring all the difficult emotions held by the tissues of the pelvic organs.

As most personal history is likely to be repressed as it is emotionally impossible to embrace as a child, just talking sexual history will not do much, but it is a good way to get

introduced, and to open up for confidence and intimacy. Do not expect verbal therapy to do much for your vulva patient; most likely she already had had several years of psychotherapy and often also psychiatric treatment.

During the talk session it is important to confront her with her own sexuality. It is also important to explain how and why “the body and mind keeps the scores” (50) so that she gets the idea of healing and the goal of being a whole person experiencing a strong sense of coherence (51,52). She must be warned that in the therapy she is likely little by little to remember everything bad that happened to her, and it must be underlined to her that these painful memories related to sexuality are the reason for her vulval and sexual problems, so they must be confronted and integrated.

The second step is the first part of the sexological examination: Visual exploration of her genitals by the physician together with the woman, which is best done using a mirror. This is quite opposite of the traditional gynecological examination, where the woman is passive; in this step the woman must be the active part, touching herself everywhere during the exam and one by one naming all the parts of her genitals and telling you about their function and in the same time about all the difficult feelings this confrontation wakes in her.

This confrontation is the most difficult thing for many women, especially if they have been abused sexually, where just being looked upon by a man will induce a feeling of shame and guilt, often it will be felt like exploitation, abuse and violation. So already here the principle of similarity is active, if you notice. The only thing for you to do is to talk with her about her reactions in all details; ask her if she finds her own reactions relaxed and natural, or tense and neurotic, and if she agrees to the latter, you need to explore this emotional reality together with her.

Talk to her honestly about your feelings and reactions also, even if you got a negative reaction to her genitals, which you are most likely to have as your reaction mirrors the emotions she is holding back in her genitals. If you feel her genitals “dirty”, “disgusting” etc, these feelings are likely to be rational reactions to the energies stored in these tissues. If you are a healthy person your reaction to healthy genitals are most likely to be healthy. So do not blame yourself for feeling what you feel, just be honest about everything and put your full trust in the process of healing.

The last, third step is also the most difficult. In this last part of the clinical medical procedure, the explorative therapeutic touch is used as vehicle for the patient’s consciousness exploration of self, sexuality, feelings, attitudes and sensations related to the vulva. In this step after verbal consent (we also recommend written consent) the physician will touch his female patients genitals, very much as in the normal pelvic examination, acting with the different purpose of educating the woman and allowing her to investigate and explore herself, her body, sexuality, genitals and related problems.

Therapeutic touch of the genitals has traditionally been done in five different ways, from the smallest to the largest of holistic medical procedures (see table 1). These tools should only be used when conversational therapy including sexual biography (step 1), and genital confrontation and anatomical education (step 2) have failed to solve the problem, and then the smallest tool of these five tools for therapeutic genital touch, that is likely to cure the patient, should be used. (53)

Often the first session or a few more will be only talking, the second general bodywork on the couch, and the third or fourth session will involve the patient’s genitals. The manual therapy often continues for 5-10 sessions or even more, over one year, before the patient’s

problem is solved. If 20 sessions during two years does not help, it is not likely that the holistic medical method works.

Some patients will need a pelvic examination on the first visit for the physician to evaluate if holistic treatment is likely to help the patient sufficiently, or if some bacterial tests, antibiotic etc. drugs, involvement of specialists for anti-cancer surgery and radiation therapy etc. are also likely to be necessary. The ethics of the treatment must be up to standard, and violating this trust will seriously ruin the patient's chances of getting the help she needs from the treatment (54).

Table 1. The five tools for manual sexology (53)

1.	Acceptance though touch (55)
2.	Vaginal acupressure (37,38)
3.	Pelvic Examination (56)
4.	Holistic Pelvic Examination (56)
5.	Full sexological examination (2-7)

The five tools

You can practice manual sexological therapy for sexual/genital healing on many different levels. The ethical and rational physician will carefully take one step at a time, and only use the resources necessary and the smallest tools that actually will do the job.

Interestingly just a minimal therapeutic touch of the patients pelvis/genitals (mount pubis or upper vulva) is sometimes curative as the therapists intention of acceptance signified through the therapeutic touch often heal the patient who suffers from simple genital pain and discomfort caused by repressed feelings like shame and guilt (55) The next step is intra-vaginal/anal massage/acupressure, which is also the classical procedure of Hippocratic Pelvic massage (36-38) which is identical, or at least very similar, to the explorative part of the common pelvic examination. The only difference consist in the common examination of the vagina, pelvis and other parts of outer and inner genitals, which gives the female patient insight in her emotional issues and energetic blockages in this area. According to one study this procedure alone cures more than half of the patients suffering from a variety of genital problems, sexual dysfunctions and pelvic pain syndromes (38), explaining why it has been such a popular medical procedure for over two millennia.

Unfortunately about one third of patients will not be sufficiently helped by these techniques, no matter how skilful and persistent they are accomplished. In this situation it is recommended to work directly against the patients emotional resistance; this often include direct sexual stimulation, role-plays of sexual abuse etc. and according to some studies the percent of the patient helped can by this be raised to about 80-90% (57,58). Still it is quite remarkable that if only conversational therapy and non-genital bodywork were used, like in standard clinical holistic medicine, about 40% of sexually dysfunctional patients were still cured (32).

The therapeutic value from therapeutic touch comes from the fact that many patients need physical contact to release and integrate the painful, repressed emotions they are carrying in

their body from early traumas. Only this kind of support can help her attention to return to the body. It is really amazing that physical, sexual and genital healing can be done so easily – all it takes is sufficient exploration for the woman to get self-insight. The old Greek saying carved in the rock above the temple entrance in the famous temple of the oracle in Delfi, “Know Thyself” is really the key to healing, and also the core of the classical Hippocratic “character medicine”.

It is important to remember that penetration of the vagina (and anus if necessary for the patients reclaiming of own bodily space) with one or two or more fingers obligatory reminds the patient of penile penetration and sexual abuse, making this procedure extremely emotionally difficult and also extremely therapeutically efficient with sexual abuse victims. The integration of the difficult emotions and thought from traumas from rape and incest should be taken in steps also, never burdening the patient more than can elegantly be handled between sessions. Developmental crises which need intensive 24-7 care happens often with the most severely abused patients, and occasionally in patients who have very strong Oedipus complexes. Patients who have a prior psychiatric history of psychosis might experience a developmental crisis with psychotic elements, but with sufficient support this is not harming the patient (23-26). Sometimes the patients need to work with role-plays and psychodrama to get back into the painful experience of sexual abuse. Most interestingly the father’s abandonment (i.e. by leaving the home when the patient was still a little child) or sexual neglect of the patient seems to be even more harmful than sexual abuse.

The pelvic exam is often highly provocative, and is as such a large tool in the manual sexology; the obvious advantage with this tool is that it is expected and generally accepted, so it is so easy to get the patients consent to this, and nobody will question your clinical practice; the disadvantage is that you risk to re-traumatize your patient as 15% of young female patient experience this examination as very painful, and 33% as a negative experience.

Many physicians and sexologists have some reluctance to use the large sexological manual tools and many holistic doctors like Wilhelm Reich were persecuted for using them by the boulevard press, and accused of sexually abusing the patients (39). While this is not likely to be true, at least not in the case of Reich, who was known by his students and patients to have a high level of integrity and ethical consciousness, this is still an important element of our culture, and any sexologist choosing to help his patients with these tools should be aware of the danger of being discredited by bad publicity in the media.

The larger sexological tools are the holistic pelvic examination, which basically is the pelvic exam used therapeutically and finally the sexological examination itself. The later is a great tool, that have proven superior in treating female sexual dysfunctions in many studies; it is a large therapeutic tool as it in its full form includes direct sexual stimulation of the patient’s clitoris and vagina.

Many critics find that as this sometimes makes the female patient have orgasm in the clinic this is too close to having sex with the patient. For this reason this treatment has not been offered in many medical clinics in Denmark, in spite of our liberal attitude, but it is normal in CAM clinics. As our own Research Clinic for Holistic Medicine and Sexology in Copenhagen has been a medical clinic we have not offered this treatment to patients and our knowledge of its effect is limited.

But we have studied CAM therapists who have used similar techniques with surprising efficacy, even in the treatment of the most severe chronic anorgasmia-patients (58). So there can be no doubt that the largest of the tools for holistic manual sexology, the full sexological

examination, is highly efficient for the patients that needs this kind of explicit and direct sexological treatment.

Nudity is often helpful, but many patients are too shy to be naked on the couch for the first couple of sessions. The therapist hands are then placed on the stomach in vicinity of the vulva, and the emotions that the intimacy provokes are discussed and released. Gradually the vulva is confronted, and all the emotions processed. It is quite amazing how efficient this little procedure is with most patients. Even without therapeutic touch of the vulva much of the negative emotional charge related to sexuality can often be discharged this way.

The symbolic significance of the vulva

From a psychosomatic perspective the disorders of the vulva are likely to be connected to psychological imbalances and arrested psychosocial development related to the female patient's gender and sexuality. The psychological significance of the vulva is profound; the vagina is her symbolic (energetic) opening to the world, to the male partner, and to the divine (as man represents the spirit while woman represents earth) and also the source of her offspring.

From a depth-psychological perspective the woman is even held by herself in her own womb (59). The significance is so deep that it is hard to imagine and fully comprehend, and therefore the vulval disorders almost always carries hidden symbolic meanings that only reveals themselves after month or even years of analytic, psychodynamic or existential therapy.

On the other hand much is easy to understand immediately, without too deep reflections. Basically the vulva is about presenting her vagina and uterus to a male partner sexually, thus turning him on, seducing him, and in the end getting his semen and children. It is also about simple sexual pleasure of coitus and of receiving the penis in the vagina. This makes orgasmic potency an important issue, since the orgasmic potent woman is multi-orgasmic and reaches orgasm easily. If this is not the case with the actual patient this is a good issue to address verbally in the opening of the sexological therapy.

From a holistic medical point of view the diseases of the vulva cannot be separated from the female patient's sexuality, which means that the vulva cannot be treated separately from the pelvis and the rest of the human body. Her general attitude to her body is also an important issue to address.

To heal the vulva a sexual healing is needed. But the holistic perspective takes this further: To heal sexually, the patient often needs to heal at an existential level. The general quality of life is therefore also an important issue to talk about at the start of the therapy.

So what seems to be a small problem of pruritus of the introitus or pain related to the clitoral stimulation during sex can easily end up being the start of a long journey of psychosexual and human development for the patient.

The physician needs to teach this perspective to the patient, to allow the patient to assume responsibility not only for her genital and sexual health, but also for her whole life, physical and mental well-being, relations with partner, friends and family, working life, and global quality of life.

It is so easy to carry out a great number of traditional medical procedures, but as the many chronic vulva patients indicate these procedures are often unproductive and many patients have been through biological tests like bacteriological analysis, blood tests, tissue samples, they have been examined with ingenious machines like kolposcopes, vulvalgesimeters etc. and they have been given dozens of drugs without curative effects. They have now come to your holistic clinic to get what they never got, which is healing from the disorder, that has tormented them for so many years, including a resolution of the deeper, existential and psychosocial causes of their more obvious vulval symptoms.

To understand the psychosomatic dimensions of health problems related to the vulva, it is necessary to consider the natural biological functions of the vulva. The vulva contains the head of the clitoris, and thus the primary centre of the female sexual pleasure. As pleasure is often seen as bad and strongly repressed in childhood, most problems centred around the region of the clitoris is about pleasure and repression of pleasure. Below clitoris we have the orifice of the urethra, and Graffenberg showed in his famous study in 1950 (60) that the urethra played a central role in the female orgasm (thus the highly erotically sensitive locus for transvaginal stimulation of the urethra was labelled the "G-spot"). Half of all the urinary tract infections are not really infections, but only inflammations and local irritations most likely connected to problems related to the female orgasm.

Below the orifice we find the introitus and vagina; the psychosexual function of the introitus is the acceptance or rejection of the penis; the function of the vagina is first the reception of the penis, secondary the locus of pleasure and vaginal organs, and third the reception of the semen.

The function of the labia minor is to protect the clitoris, urinary orifice, and introitus, and presumably more importantly from a psychosomatic perspective to present her vulva to attract a male partner. The labia major have both these functions as well, but seem to have primarily the last mentioned function.

So the female genitals are intensively charged with sexual significance and positive and negative emotions. The emotions are typically shame, disgust and the like. The tissue often carries these emotions in them giving a strong tendency to local disturbance of the biological information regulation growth and immunological activity. The lack of normal immunological resistance is a likely cause of infections and the disturbed information is a likely cause of abnormal growth of the mucosa, dysplasia and cancer. The strong emotional charge carried by the tissue is likely to cause sterile inflammation, primary vulvodynia, and dyspareunia.

So it seems that the psychosexual developmental problems that cause the different sexological problems also are causing the physical health problems of the vulva. In accordance with this fact it might be rational to work on solving the female patients' sexual and emotional issues instead of only focusing on the physical level of the illness. To do this we recommend the combination of conversational therapy and manual sexological tools listed in table 1 (53).

The process of healing will normally take the following four steps: 1) Emotional healing, 2) Sexual healing, 3) Spiritual healing, 4) Existential healing accompanied by 5) the healing of mental and physical disorders including the vulval disorder - which was the reason for the patient visiting the doctor in the first place (see table 2) (61-63).

Table 2. The steps of healing leading to the cure of the vulval disorder

Emotional healing.
2) Sexual healing.
3) Spiritual healing.
4) Existential healing accompanied by
5) Healing of mental and physical disorders

This is quite remarkable that treatment of a vulva-disorder with integrative, holistic sexology often leads not only to the cure of the genital problem itself, but also to the resolution of many other problems related to sexuality and the one-to-one relationship. But also more fundamental personality disorders and even severe mental disorders like depression and schizophrenia has been reported resolved, when sexuality is healed.

Freud and Reich seemed to agree about describing three steps of female sexual maturity: 1) the most immature called infantile autoerotism, 2) the immature sexuality only including the patient herself often called the masturbatory or clitoral state, and finally 3) the mature, genital sexual state called the vaginal state (8,39).

It is not difficult at all to identify the level of sexual maturity when you discuss these steps with your patient. If the patient is able to obtain multiple full vaginal orgasms she is likely to be sexually mature; if she can get clitoral orgasm when she masturbates or stimulated, but not a vaginal orgasm during intercourse she is likely to be at the second stage; and if she cannot make use of her sexual energies at all, she is likely to be in the state of infantile autoerotism.

Sense of coherence

The most important concept in relation to clinical medicine and clinical holistic medicine is the concept of experienced sense of coherence. This experience of being an integral part of the world is the existential core dimension that must be improved to induce existential healing or salutogenesis according to Antonovsky (51,52).

The process of healing (64) has been neglected in contemporary biomedicine, and we need to go back to the Hippocratic roots of medicine to understand healing. The patients become well again, claimed Hippocrates and his students, when the patient once again feels one with the universe (or “loved by God” in religious terminology). In the natural and realized state of being man is able to step into character and use all talents to be of value to the surrounding world. Because of this fundamental idea of self-realization in medicine the original European holistic medicine has been called character-medicine. Hippocrates and his students knew that health came from feeling wonderful, being your natural, free and happy self. For over two millennia this has been the answer to the prayers of cure, good health, and lasting good fortune.

Character, Wilhelm Reich said, is fundamentally about gender and sexuality; and only if you integrate you sexuality into your personal character can you be you true self. Reich therefore called the mature human character for the genital character of the patient. It is quite interesting that the patients approaching the clinic with problems related to the vulva often to

an extreme degree have avoided integrating the genital sexuality into their personal character. It is the rule more than the exception that the female patient with vulvodynia, lichen planus or recidivate urine tract infections are neurotically orderly, hygienic, nice to everybody and obsessed by pleasing other people, instead of being selfish, autonomous, independent, self-confident, and focused on the talents and gifts that makes her an exceptionally valuable and alive person, who deserves the greatest of joys and pleasures humanly obtainable.

Often severe personality disorders go hand in hand with severe sexual and genital problems as already Freud, Jung and Reich noticed. If you as a physician realize that there might be a simple causal link between the immature, sexually irresponsible attitudes and behaviours of your vulva patient, you will feel the obligation to turn the patient's attention towards this hidden order. If you are not trained in psychoanalysis or depth psychology, and if you only have a little training in sexology, you might in the beginning feel it quite difficult to do so.

Healing the disorders of the vulva

The diseases of the vulva can be categorized into sexual and non-sexual problems as listed in table 3. In most cases the holistic clinic addresses the chronic disorders and diseases that remain after an unsuccessful treatment by the patient's own physician or gynaecologist. In general holistic medicine is effective in pain (NNT=1-2), discomfort, low self acceptance (NNT=1-2), and for all disorder where the biological order (i.e. tissues, organ structure, body form) is disturbed (NNT=2-3), or immune function is too low (recidivate or treatment resistance infections) (NNT=2). Problems caused by sexual traumas like rape is almost also successfully treated with holistic mind body medicine (CHM) (NNT=1). In general sexual dysfunctions and psychosexual developmental disturbances are treatable (NNT=1-2).

The chronic or recidivate vulvo-vaginal inflammations and infections that is treatable with holistic methods, although the NNT for successful healing is not yet known, includes a number of diseases: Lichen sclerosus, papillomatosis, seborrhoeic eczema, allergic eczema, irritant eczema, Lichen simplex chronicus, vulvar psoriasis, Lichen planus, vestibulitis, ulcerating and blistering disorder, and erythema multiforme. Patients suffering from fungal and viral infections, like *Candida albicans*, erosive vulval candidiasis, tinea cruris, genital herpes simplex, recurrent varicella zoster virus, *Moluscum contagiosum*, genital warts and human papilloma infection, and *Staphylococcus* infection (bacterial impetigo), all of which can be rather resistant to pharmacological treatment often heals or improves when immunological resistance is increased though improvement of patient quality of life in general - and genital self acceptance specifically.

Recidivant crab lice (*Phthirus pubis*) and scabies (*Sarcoptes scabiei*) often takes a life style improvement to prevent, as do multiple reinfections with gonorrhoea, syphilis, vulval chancroid, bacterial vaginosis, trichomonas vaginalis.

A number of degenerative and atrophic disorders of the vulva (genital aphthae, Behçet's disease, necrolytic migratory erythema, Crohn's disease of the vulva, Bullous pemphigoid, pemphigus vulgaris, pemphigus vegetans, vulval scarring from cicatricial pemphigoid, Epilation folliculitis, apocrine acne, hidradenitis suppurativa, idiopathic labial oedema) have no

pharmaceutical treatment, but holistic intervention is applicable. Again, the NNT numbers for the treatments of these diseases are not known.

Table 3. The most important non-sexual and sexual health issues related to the vulva

“Non-sexological” diseases	Psychosexual developmental disturbances (symptomatic eating disorders like bulimia and anoxia nervosa, self-esteem problems, lack of genital self esteem etc.)
Vulval and vaginal infections (STDs and non-STDs)	
Skin problems such as lichen sclerosus, lichen planus, and lichen simplex chronicus and other problems related to the mucosa	Problems after sexual traumas like rape or incest
Vulvovaginitis (VVS) is inflammation or infection of the vulva and vagina.	
Chronic burning, pain, and irritation (including pruritus)	Female ritual circumcision
Vulvodynia (chronic vulvar pain, most often described as a burning discomfort, whose specific medical cause cannot be found).	Problems related to the trauma
Precancers (dysplasia/carcinoma in situ)	Problems related to self worth and self acceptance
Cancers, metastatic cancers Pelvic/perineal/perianal pain syndromes	Problems related to sexual pleasure
Sterile (50%) and non-sterile (50%) urinary tract inflammations	Holistic treatment of cosmetic problems
PMS, amenorrhea	Problems of the breast – acceptance, size, shape
	Problems of the vulva/labia – acceptance, size, shape
	Problems of body shape and sex character
Sexological dysfunctions	
Desire problems including lubrication problems	
Excitement problems	
Orgasm problems	
Vaginismus	
Dyspareunia	
Sexual pain (from negative emotions, tensions)	
Sexual aversion syndrome	

Holistic treatment of benign gynecological tumors like: Acrochordia (skin tags), venous varicosities, keratinous cysts, mucous cysts, papillary hidradenoma, genital syringomata, giant venous ectasia, maematocolpus, endometrioma, benign melanocytic lesions, lentigo simplex, vitiligo, Idiopathic aquired pigmentation of Laugier, are often the only alternative to surgery of the vulva, which might be rather traumatic and reduce future sexual functioning.

Holistic treatment of malign gynecological tumors, like Intra-epitelial neoplasia (Bowenoid papulosis, Bowens disease) malignant diseases like squamous cell carcinoma, vulval lymphangiectasia, Verrucous carcinoma of Buschke-Löwenstein, Paget’s disease of the vulva (intra-epidermal adenocarcinoma), Langerhans’ cell histiocytosis, Basal cell carcinoma, malign melanoma is always a good supplement to biomedical treatment. When there is no documented success with chemotherapy or surgery, holistic treatment might offer

some comfort in a palliative intention, and might even induce spontaneous remission of cancer in the best case, as have been seen with other kinds of cancers (10-16).

Holistic treatment of female ritual circumcision focuses on healing the trauma, and rehabilitating to self worth and self acceptance, and finally recovering the ability to sexual pleasure. Contrary to the normal belief most circumcised females can still have a normal sexual life with vaginal orgasms, if their psychological problems are solved.

Holistic treatment of cosmetic problems addresses the surprisingly frequent subjective problems related to the breasts – accepting their size, shape and other qualities – and genitals, especially the vulva. The labia minors can be a big problem for many women who cannot accept their size, shape, feel etc. Such problems are almost always efficiently solved in the holistic vulva clinic. Other problems easy to address in holistic mind body therapy are problems related to lack of acceptance of body shape and sex character in general.

Holistic treatment of low genital self esteem addresses the problems related to lack of genital self-esteem and self confidence and fear to express own sexual character due to low self-worth, shyness, repression by parents etc.

From a holistic, psychosomatic perspective, health problems of the vulva are as a rule always related to the female patient's sexuality. This fact is often quite inconvenient for both the patient and her general practitioner. Sexuality is still a taboo and many patients do not discuss this subject easily, even with their doctor. It is much more hygienic and nice, if a vulva problem just could stay a medical problem; if it turns into a problem of the patients' psychosexual development it means that the female patient must do some serious homework or even therapy related to personal development to solve her health issue.

The journey of the patient

It is quite an interesting journey to follow the female patient as she grows sexually. To grow into the mature woman all she needs to do is to get rid of the repression of her sexuality. There are two major elements here: the negative feelings/emotions, and the mental negative judgment. So she needs to shift into a sex-positive mental attitude, and she needs to confront and integrate all the difficult emotions of shame, not being good enough, being ugly, being unwanted, not being attractive, being disgusting etc.

As mentioned about major tools there is a need to take the patient through her sexual history, asking her to write her sexual biography and using this as basis for further investigative talks. Often this is not enough; the genitals and the painful emotions related to every part of them needs to be confronted. After the negative emotions have been confronted it is normal that the positive sexual feelings appears, and when this happens you know that you have done a good job clearing your patient of the layers of emotions that repressed her sexuality. Unfortunately there are many layers of this process, and when she has freed one layer of her sexuality her whole personally starts to reorganize, making it possible to access the next layer in the next session. So do not think that everything is coming back, when the problems are getting worse; it is just other problems appearing from a deeper layer.

After 5 or 10 sessions you will often reach a layer of spiritual depths; she will start to talk about her love life and personal relations, and you can now start the process called spiritual healing, where she can start exploring new depths of her love and meet soul to soul at a

deeper level with the people in her life. After 5 or 10 more sessions she will often realize that she has talents and characters that has now been used, and when she starts being the talented, gifted and loving, generous persons she was meant to be, you have reached the existential level. When she systematically uses herself to be of value to everybody in her life, she will also notice a huge transformation of her attitudes and behaviours in the sexual domain and normally, this is the time where the vulvodynia, lichen planus etc disappears. It is quite amazing to follow this human transformation, from neurotic, sexually afraid, concerned about her bad health and genital problems, into the vital, happy, self-confident, generous and loving person.

You as the holistic physician has become the catalyst for the process that we often call *adult human metamorphosis*, because it is so similar to a caterpillar transforming itself to a butterfly. It is not difficult at all to help people grow. The trick is to understand emotional healing. As soon as you do that, and start helping your patient integrate old negative emotions and change old negative attitudes, the healing journey has begun. Do not think that you need to be a therapist or psychoanalyst to do this. Just be a loving person, using yourself as the tool, and be of service to your patient with everything you got.

Discussion

The use of the manual sexological tools has to be preceded by sufficient conversation therapy and careful, ethical considerations and also explicit consent after thorough explanation of the full procedure. To avoid setting the patient back in the therapeutic process, physicians have for millennia accepted the Hippocratic ethics of not having sex with the patient, and we strongly recommend the sexologist to respect and comply with this ethic rule. The problem here is really how we define “sex”. If genital stimulation is sex, then the sexological examination is sex. The wise thing is to make the definitions practical; if we define sex as coitus and oral-genital contact, we have solved the problem, but this is hardly correct. Sexuality is everywhere, and we can circulate sexual energy even without physical contact, as anybody who has flirted will know.

So the debate about sexual ethics should be reasonable; the contact between a female patient with a vulva disorder and her physician should not be seen as sexual, even if the physician manipulate her genitals and even if she feels pleasure from this manipulation. Only if we can allow the healing touch also to be pleasurable, can we use manual sexological procedures, which in the beginning will be only painful and difficult; the pleasure is the sign of the problems being solved. Every physician should put up his own borders and stick to the tools that he or she finds ethical and appropriate. The only important issue is the ethical rules of this kind of therapy that must be kept in mind at all times and written consent paramount.

To be effective in the vulva clinic as a physician, therapist, gynaecologist, or sexologist we suggest that you forget all your traditional school-medicine and start being a human being sitting there with another human being that desperately needs your help and assistance to get self-insight and through this the physical, mental, existential and sexual healing offered by clinical medicine. A vulval disorder is in many aspects a severe handicap. It is a hindrance for a sexual relationship, a normal partnership, a high bodily and genital self-esteem, a good self-confidence, and a high quality of life. You will also often realize that your patient has been a

chronic vulva patient for 5, 10 or 20 years, so if she is to get help at all she will most likely get it from you.

You will realize that you can only help her if you dare to involve yourself as a whole person and use yourself as a whole person as the tool for healing – the doctor is the tool (49). You might even experience the danger for your ego of stepping down from the traditional expert-role, to be just another human being helping and giving loving care and acceptance to another human being. Vulval disorders often need an integrative approach where medicine, gynaecology, sexology and psychology all are important subjects needed to help your patient. Interestingly this becomes very simple in the concept of clinical medicine, where the physician and the patient in common explore the problem, confronting all connected issues like feelings and emotions, physical body and the sexual organs, the patient's sexuality and psychosexual development and in the end give the patient the self-insight needed for healing.

There are about 50 randomised scientific studies related to manual therapy and holistic sexological treatments for the clinical condition related to the vulva and pelvis, and the vast majority of these indicate that holistic treatment is efficient, as fifty to ninety percent (NNT=1-2) of all such patients normally are cured (1-7,32,38,65). As there are no known significant side effects of the holistic sexological treatments (NNH=64,000 for brief reactive psychosis (23-26)), so we believe holistic medicine and sexology are safe for the patients.

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How to avoid the Freudian trap of sexual transference and counter transference

Sexual transference and counter transference can make therapy slow and inefficient, when the libidinous gratification becomes more important for both the patient and the therapist than the real therapeutic progress. Sexual transference is normal, when working with a patient's repressed sexuality, but the therapeutic rule of not touching as seen in in most psychotherapy often hinders the integration of sexual traumas, as this process needs physical holding. So the patient is often left with her sexual, Oedipal energies projected on the therapist as an "idealized father" figure. The strong and lasting sexual desire for the therapist without any healing happening can prolong the therapy for many years, as it often does in psychodynamic psychotherapy and psychoanalysis. We call this problem "Freud's trap". Freud used intimate bodywork like massage of the female patient legs in the beginning of his career, but stopped presumably for moral and political reasons. In the tradition of psychoanalysis touch is therefore not allowed. Recent research in scientific holistic medicine (clinical, holistic medicine, CHM), salutogenesis and sexual healing has shown, that touch and bodywork (an integral part of medicine since Hippocrates) are as important for healing as conversational therapy. The combined holding and processing of holistic medicine allows the patient to spontaneously regress to early, sexual and emotional traumas, and heal the deep wounds on body, soul and sexual character from arrested psychosexual development.

Modern sexology and holistic medicine treat sexuality in therapy more as the patient's internal affair (i.e. energy work), and less as a thing going on between the patient and the therapist (i.e. transference). This accelerates healing and reduces sexual transference and the need for mourning in the end of therapy.

Introduction

There is plenty of literature on the need to work in abstinence, and almost every therapist on the planet agrees with the Hippocratic ethics of avoiding sexual contact with the patient.

Sexual transference and counter-transference is therefore a concern in psychoanalysis and psychotherapy, but there is a scarcity of papers analysing this mutual libidinous gratification in spite of the issue being highly disturbing to so many therapists (1).

A few years back Irvin D Yalom, the father of “existential psychotherapy” (2) on a visit to Copenhagen addressed the taboo of sexual feelings in therapy directly by declaring that: “I have been sexually aroused by patients and so have every therapist I know”. A participant in this conference and teacher in psychoanalysis was somewhat uncomfortable by admitting that he, in the end of a very difficult, almost 10-year long, four-sessions-a-week analysis with a mentally ill, sexually abused, female patient, had an erection. But this event signified to him more than anything else that the patient had finally successfully healed not only her sexuality, but also her basic existence; but he still felt uncomfortable to be aroused by an abused patient, especially as he earlier in the therapy was projected as the abuser in the transference.

We must face the fact that therapists are human beings with the same sexuality and also the same feelings of shame and guilt as other people. This means that whenever a man and a woman are together, and they share intimate details, this will affect them sexually (3-6). There will always be some internal reaction, and also some reaction towards the other, i.e. transference and counter transference of love and sexuality, and sexuality thus ceases to be entirely the internal affair of the patient. The ethical art of therapy has since the days of Hippocrates been not to act out on these feelings (7).

Any relationship needs an investment of energy to be of any importance, and this energy is our life energy, which is very sexual, as Freud noticed correctly (8). When the therapeutic relationship turns sexually rewarding, the therapist must guard his intention at all times and be certain that he intends to help the patient, not to engage in the libidinous gratification, however pleasant and however unavoidable.

Unfortunately, the subconscious drive often wins over the mental and spiritual interest of curing the patient, and in this case the therapy often gets stuck. By addressing the sexual healing explicitly and directly, the therapy can move on, but if this does not happen, the therapist and the patient are often hopelessly trapped in what we call the “Trap of Freud”: the continuous libidinous gratification that will make the patient pay for many sessions with no real progress, and with great, prolonged, and painful mourning in the end.

It is difficult to know when this state has been reached; one sign of this problem might be that the therapist is starting to dream and fantasize not only about coitus with the patient, but also about actually marrying him or her; on the other hand such fantasies might be necessary for the therapy (4,5). We must admit that therapy in this situation has almost turned into a real “marriage” between the therapist and the patient. There are so many similarities to marriage that the only major difference is the lack of physical acting out.

For Searles the difference between fantasizing about marrying or having sex with the patient and actually doing so is crucial (4): Without the fantasy sexual energy is not available for therapy, but without the taboo on acting out this energy is channelled into the sexual relationship with the therapist not the therapy; this taboo however brings mourning because the desired relationship is sacrificed for the therapy. But Searles also worked under the taboo of touch, and from our perspective this unnatural distance to a person you care for, is what created the accumulated, and stagnant, libidinous energy experienced by Searles, and thus the fantasies. In one study Searles worked for 900 hours on average with the patients (9).

Sexual transferences and counter transferences are not bad for the therapy; brilliant therapists like Freud and Searles believed that transference and counter-transference of love

and sexuality was necessary for therapeutic progress, but they must be used wisely (3,4). The need for sexual healing must be acknowledged, and the therapy must address this need directly in order for therapy to progress efficiently. In order for healing to take place (according to the theory of holistic healing (7,10), see discussion below) it is necessary to provide the patient with the support and holding needed for spontaneous regression back to the traumas. What most patients need is according to the Hippocratic medical tradition physical and mental contact, love, respect and acceptance, honest conversation, and physical intimacy (11,12).

According to some experts, Freud and the other psychoanalysts stopped giving physical holding precisely *because* it encouraged sexual gratification, but this could also be a way to signal to the surrounding world that now sexuality was under control in the therapy. Physical contact and therapeutic touch has been an integral part of holistic medicine since Hippocrates, and Freud was of course familiar with this tradition.

So we find it highly unlikely that Freud really believed that stopping bodywork would solve the problem of therapists acting out; probably Freud who was a politically cunning developer intended to modernise the somewhat old-fashioned holistic medicine, and take it into a medical practice that could be widely accepted and used by his contemporary fellow therapists. We know from his many writings that Freud often reflected deeply upon what could be accepted by the press and contemporary culture and what could not.

Most interestingly, the energy needed for deep existential healing (salutogenesis) (13,14) is what we would call of a maternal character; if patient receives a nourishing, female, motherly energy, he or she will often spontaneously regress into and heal from his early, infantile, sexual traumas. It is important though that the therapist is not excluding the male pole in his contact with the patient, as treating the supportive energy as only a maternal energy can lead to a serious denial of sexuality.

In many pre-modern cultures the medicine man was a person of “double sex”, being able to be both father and mother at the same time. The same idea is prevalent in today’s Indian yogis; the famous yogi Sai-Baba’s name meaning literally mother-father. The Jungian idea of an inner opposite sex (anima and animus) was an important development in psychoanalysis (6) and many psychoanalysts believed that Freud’s limited ability to help the schizophrenic patients was due to his lack of willingness to be the mother. Let us quote Harold F Searles in one of his fine passages:

“My impression is that Freud himself clung to this father-transference role in order to avoid facing the anxiety associated with the patient’s working through their earlier conflicts in relation to him as a mother in the transference. This is a clue, I think, to why Freud considers schizophrenic patients, in whom the resolution of such conflicts is crucial, to be insusceptible to psycho-analytic therapy.” (5:440).

Most interestingly the re-parenting and the care for spirit, mind and body at the same time is also what characterized the original Hippocratic character medicine (7). Many of the Hippocratic procedures had the purpose of re-balancing the sexual energies, especially of the female patient who received pelvic massage (7,15-17). The indication for this treatment was “hysteria” (from Greek Hystera: Uterus), believed to signify a broad range of female, mental illnesses. This treatment (also called vaginal acupressure) give intense physical holding to the female patients body, including the genitals (15,16) allowing her to regress and heal infantile

sexual traumas related also to infantile (auto)erotism (see below). This treatment is thus highly rational from a psychodynamic perspective, in spite of obvious, ethical problems (15,16) (see below), which presumably inspired the Hippocratic doctors to developing their famous ethics.

Sexual transference and counter transference

Sexuality is ubiquitously present in nature and two sexually sound people will always to some extent have some bodily sensations of sexual nature provoked by each other's body. If we were just animals, sexual interest would be constantly and openly present. Being composite creatures with body, mind and spirit, and Id, Ego and Self (soul, higher self), the bodily part of us is constantly interested in sex which are in many ways sublimated, as Freud ingeniously noticed, as much of our natural interest in other people come from sexuality, but is turned into mental and spiritual interest. Researchers in tantra (18) have noticed, as Freud, that our mental and spiritual energy basically is transformed sexual energy. And here it is important not to fool yourself: It is still sexual energy, just in a more socially acceptable form.

Having stated these plain and well-known facts, we can take a deeper look at sexual transference and counter transference. This has been a strong taboo in psychoanalytic and psychodynamic psychotherapy (1), and from the very beginning it was considered a serious threat to the reputation and practice of psychoanalysis (3:170). The reason for the taboo is not very surprising, because who will send their sick young daughter to a man whose primary interest is to engage his sexual energy on her? So psychoanalysis has from the very beginning, in spite of Freud always stressing frank honesty as a key value, made very smart cover-ups, especially in the language it has been using. Most people do not realize what the Oedipus conflict is about, and they do not want to know either, for this issue is far too provoking. Most sexual transference seem to be of Oedipal nature; that was the reason for Freud to develop this seemingly strange Oedipus theory: It seems that the nurturing relations between children and parents are carrying extremely strong, but often unconscious, sexual feelings; and this energy is very often materializing itself in therapy, when the patient is regressing to early childhood scenario, and projecting father or mother (or both) on the therapist (10). But Freud did talk about this mother infant bond as sexual in a broad sense. Psychoanalysis has had to operate throughout its history with a tension between its highly sexual theories and its wish to be accepted in a repressive culture. It hasn't always got everything right, but it would be over-simplistic to simply say it has covered up sexuality.

These subliminal or conscious sexual complexes and feelings in psychodynamic therapy and psychoanalysis have been sought resolved in a simple way. When years of intensive contact in the therapy have finished its sexual-energetic process, its natural end is a very intense and prolonged mourning. This whole process often takes years and during this time many patients will stick firmly to their symptoms, since these supply the patient with a justification for staying in the most intense, intimate and pleasurable psychosexual contact to another human being they have ever experienced.

Meetings four times a week for years are not unusual – literally thousands of sessions. The obvious lack of progress in therapy is understandable if we acknowledge that our body

has priority in our subconscious universe controlling so much of our behaviour. This trap of psychoanalysis must be avoided at all cost, as it makes therapy expensive and inefficient.

We know of course that some psychoanalysts might find our analysis hard to accept, and from a traditional psychoanalytical position it is clear, that what we have stated above could be seen as a misunderstanding and oversimplification of psychoanalysis on a number of fronts. Firstly, psychoanalysts could argue, the mourning is in part at least because of the lack of sexual gratification not because of the loss of it. In the same way the incest taboo between parents and their children is what compels them to form sexual relationships outside the family of origin. But there is a kind of mourning involved in the acknowledgement that although daddy finds the child lovely he is married to mummy and therefore not available. And as the many fine statistics have documented (9), it is not correct to say that no-one benefits from or needs long-term therapy. Another argument that could meet our position in this paper is that it promotes a 'one size fits all' type of philosophy that might not be correct; it might simply be that some types of patients need many years of dialog and verbal therapy, and not bodywork.

Our aim with the ongoing research is to develop more effective and fast therapy, so it might definitely in the end turn out that we have been too optimistic of the methods of clinical holistic medicine and the combination of psychotherapy and bodywork. But for now, we prefer to stick to our optimism, especially as this optimism in itself seems to accelerate therapy immensely.

The only way to accelerate the process is to address it directly and consciously to abort the more or less unconscious, mutual plan of a sexual-energetic long-term "marriage". Actually it is well-known from analytic literature (3-6), that both therapist and patient have such intense and ongoing fantasies of sexual intercourse and marriage. And it is, from our perspective, not a shame, not a bad thing, but a biologically and completely natural thing, but still a trap that we definitely must be smart enough to avoid.

The only way to avoid being caught by the subliminal sexual rewards of therapy is to address sexual issues openly, and get the therapy going at a well-defined and high speed. We must talk openly about sexuality, address sexual transferences and counter-transferences as soon as they are noticed, keeping the focus on the goal of therapy, and avoid being afraid to take the patient in deep regression and earlier sexual traumas by using the holding and support needed for this, including therapeutic touch.

The roots of Freud in holistic medicine

Interestingly, Freud did work rather intensively with therapeutic touch in the beginning of his career, very much in the Hippocratic tradition of the holistic medical doctors, but stopped giving physical holding to his patients as he continued to develop psychoanalysis. Lauren Nancarrow Clarke wrote (19:8):

"Freud (20) used physical, body-to-body touch as one of his therapeutic tools... Freud, in several recorded case studies, performed the necessary leg massage and rolling for his hysterical patients to help alleviate their symptoms (see Fraulein Elisabeth von R.'s case, for example). Although touch is not the primary focus of this study, Freud's use of touch raises interesting thoughts about the 'touch taboo' in psychotherapy (21). Additionally,

while this practice has been lost, the creator of psychoanalysis thought that touch was an important part of the healing process. If one of the patients' main modes of communication is through the bodily symptoms, why is this no longer an area of focus for all clinicians working today?"

It is well known from "The cocaine papers" (22) that Freud did much of his research into the psyche on cocaine, which has a well-known tendency to enhance libido (the large need of self-medication for sexual problems might be the reason why cocaine is available on every "black market" on the planet). It might very well be that the continuous use of cocaine is not very compatible with intimate bodywork, if you want to avoid acting out, but a much more plausible reason for Freud to abandon bodywork was extremely tense sexual-political and moral situation at that time (Freud talked about "highly explosive forces" (3:170), making physical contact with a patient questionable, even for a physician.

Use of bodywork

Holistic doctors have used bodywork since Hippocrates. Freud abandoned it, but many therapists after Freud, like Wilhelm Reich (1897-1957) (23), continued to use it and noticed that bodywork really was extremely effective in healing by sending patients back into earlier sexual traumas, including unsolved issues relating to infantile sexuality. Unfortunately Reich did his therapy in a way that, in spite of it being scientific (and also traditional) (17) was seen as a treat to the therapists and physicians of his time, namely by direct sexual stimulation of his female patients. This situation led to the dramatic actions of burning his brilliant books with his unique research on human sexuality and a jail sentence and death of heart failure, while in jail.

In Denmark after two sexual revolutions (in the 1960s and in the 1990s) and legalization of both pornography and prostitution with pornography in every store and almost every TV-program-package, and even with porn-stars becoming TV-heroes on national TV, we still have problems with this kind of explicit, manual, sexological therapy. Today we can talk openly about sexuality, we can use bodywork to take patients into regression, but working directly with sexual stimulation of the patient in the sexological clinic is still highly controversial. Direct sexual stimulation of patients with vibrators for clitoral use are coming into use in holistic sexological therapy by alternative therapists, like the Danish sexologist Pia Struck, who like a dozen other Danish therapists have been trained in this method by the American "mother of female masturbation", Betty Dodson (24). Direct sexual stimulation during therapy must be considered classical tool of holistic medicine (17) and is therefore listed as an advanced tool of clinical holistic medicine (25); its rationale seems to be to induce a sexual opening when the patient's sexuality has been definitely shot down since early childhood. It might be this ancient tradition of holistic, manual sexology that Freud tried to get away from by inducing the taboo of touch.

The bodywork needed for inducing healing, when the patient has strong sexual transference, is not sexual stimulation, but often just simple therapeutic, accepting touch, which can be done while the patient has the clothes on (18). More intensive holding can be given with the patient partly undressed or nude (19) and with more therapists and holders (20), without touch becoming sexual. Acceptance through touch (19) and vaginal acupressure,

also called Hippocratic pelvic massage after its appearance in the famous Corpus Hippocraticum (7,17), seems to be valuable tools for giving intensive holding and support to the sexually traumatized female patients (26,27), without direct sexual stimulation.

Interestingly vaginal acupressure is equivalent to the explorative phase of the pelvic examination; we therefore believe that this procedure is legal in most countries. But as a therapist you must be absolutely certain that a holistic medical procedure is legal in your country and that you have the needed therapeutic competency, ethical training, and supervision, before using it.

We have noticed at the Research Clinic for Holistic Medicine in Copenhagen that sexual issues and severe existential problems after rape and sexual abuse often can be solved in only 10 to 20 hours of holistic therapy, if sufficient bodywork is included, when needed (16,28,29). The extreme acceleration of therapy from up to 2,000 hours of psychoanalysis (one hour four times a week for 10 years) to 10 or 20 hours of scientific holistic therapy has been the main reason to include therapeutic touch (18) in our development of clinical, holistic medicine (20,30-32). If one as a therapist dares to go all the way to working with direct sexual stimulation in the holistic, sexological clinic, even the most severe and chronic, sexual problems and dysfunctions can be solved; an example of this is the treatment of anorgasmia, where even in the most difficult cases of lack of orgasm and desire lasting for decades could be solved after only 15 hours of intensive therapy (24). Struck and Ventegodt (24) found that 93% of 500 patients with anorgasmia were cured in this way and the method had no negative adverse effects. Unfortunately, not many therapists would like to work so directly with the sexuality and genitals of the patient, as it is possible to do with the most radical, advanced tools of holistic, sexological, manual therapy. But in most cases simple therapeutic touch will do the job. We must strongly recommend that therapists acknowledge the value of manual therapy and the need for physical holding, because many problems are coming from our childhood and a condition, where we did not get sufficient love and care from our parents. When we spontaneously go back to these days of early childhood in the therapy, we simply need physical holding – as we did then (7,10). Psychoanalysts, who defend the taboo of touch, have disputed the need for physical holding. It has been a constant experience from many therapists now, working on hundreds patients with many different diseases, that touch is often needed for a complete healing of childhood traumas (33-35). The reason that therapeutic touch is needed seem to be the way information is transferred from body to body, by direct transference of biological information (36-45); especially when the patient has been sexually abused it seems that touch is a key to healing (33-35).

Using sexual energy in healing

Harold F Searles (1918-) wrote in his excellent paper on "Sexual processes in schizophrenia (5:441):

"This vignette brings up the point, too, that as the patient and therapist encounter prolonged periods of mutual despair at ever resolving the illness, both experience powerful urges to give up the difficult struggle towards a genuinely psychotherapeutic goal, and to settle for a much more primitive goal of finding sexual satisfaction in one another."

Here we see the conflict in the therapy. The mutual sexual interest is on the one hand what sets the patient free energetically and consciously and motivates for the often-painful exploration into a wounded existence. On the other hand the same mutual, sexual interest can be fixating the therapy until it breaks down in mutual despair and reveal its true, sexual nature. Searles continued (5:441):

“One may see this phenomenon when mutually gratifying investigative work is interrupted, for long weeks and even months, by a recrudescence of the patient’s defensive withdrawal. The therapist, having tested the pleasure of carrying on a relatively high order of collaborative therapeutic investigation with the difficult patient, now has a reason to feel that such gratifications are irretrievably gone, and he apt to be preoccupied more than usual by sexual feelings towards, and fantasies about, the withdrawn patient. Such sequences suggest the extent to which the gratifications of psychotherapeutic or psycho-analytic work represent sublimations of libidinal impulses, which break down, for varying periods of time, during such periods of withdrawal... in the relationship between patient and therapist. Just as sexual behaviour by a schizophrenic person may represent his last-ditch attempts to make or maintain contact with outer reality, or with his own inner self... so the therapist sexual feelings towards the withdrawn patient may be, in part, an unconscious effort to bridge the psychological gulf between them, when more highly refined means have failed.”

What Searles shares with us here is extremely important: Behind the independent interest of our Id and Ego we still have the intentions of the self, and if the therapist is conscious of his intentions and constantly intends to serve his patient every second of the therapy – which is the real challenge of being a therapist – then sexuality might serve a higher and healing purpose. So Searles noticed in himself that his sexual interest in the patient actually was embedded in his good intent for this patient – as is our physical interest in our children, when we are good parents. So after all, being a therapist is not that difficult – one must just be like a good parent.

Transference or regression

One cannot avoid sexual transferences in psychodynamic therapy of any kind, but by focusing directly on the triple rehabilitation of body, mind, and spirit (id, ego, and self/soul) one can take the focus from mutual interest here and now – which is good for confidence and trust but bad for therapeutic speed – to the crucial rehabilitation of the patient’s talents of body, mind, spirit, love, consciousness and sexuality. Working on these issues seems to be what heals the existence of the patient, i.e. induces the salutogenesis.

The therapeutic schools hold somewhat different opinions on regression; according to most contemporary schools and to holistic medicine in general, salutogenesis is happening, when the patient regress back to the painful moments, where striving for survival forced her/him to stretch fundamental existence and reshape personality at its core. We have coined this radical and total human transformation into a more hardcore and survivable version of “juvenile human metamorphosis” and the deep process of existential healing similarly called “adult human metamorphosis” (33-45). These states are so painful that only the most intensive holding can give sufficient support and often this takes all the intimacy the patient

can get. These processes can be extremely resource-demanding, if the patient is severely traumatized i.e. by repeat rape or sexual abuse in childhood and they are best done in a group setting (29). The “healing crisis” that the patient enters into is well described as “holy madness”, and the therapist is well advised coming from the concept of “crazy wisdom” (46).

Interestingly, when holistic therapy is done with a strong intentional focus on love, consciousness and sexuality, transference is mostly prevented and the healing process focused internally in the patient. In the process of salutogenesis (7,13,14,47-52) not only the mind heals (53), but also the body (54), sexuality (28) and life as a whole (55,56).

So by working on body, mind, and spirit at the same time, much human suffering can be alleviated and most interestingly even the working ability is given back to the patient. Scientific holistic therapy is therefore also helping the patient’s economy, which should be very much appreciated by poor patients, and equally by the states that offers free health service to its citizens.

To return the patient to society, initiating a process that in the end turns the patient into a valuable person for him-self and others and for society at large is the finest goal of therapy, and the only goal that really served the purpose of rehabilitating the patient’s character (7) and by that also his sense of coherence (13,14) and purpose of life (57).

Fetal sexuality and infantile autoerotism

From research in the tradition of tantra (18) we know that sexual health is associated with the ability to contain large amount of sexual energy. We also know that the ability to control the letting go and action out of this accumulated, sexual energy is essential to sexual health. Problems with containing sexual energy is often experienced as a tension or a pressure, leading to emotional lability, premature ejaculations, frigidity, and many other problems related to sexually and personality (2,3,6,7,8,18,20).

Most interestingly the therapeutic regression into infantile sexually is healing our ability to contain huge amounts of sexual energy. The regression into early childhood and into the womb as a foetus is often an extremely sexual experience, but the sexual energies are internally circulated, not circulated between self and other persons, as in mature sexuality. Freud called this “infantile auto-erotism”, and believed that schizophrenics were ill, because they were stuck at this level of psychosexual development (5:429), very much in accordance with our own observations from deep therapeutic regression of such patients.

It seems that only if our inner, sexual energy system is well functioning and healthy, that our body and mind can be healthy. It seems that early traumas arresting our psychosexual development at this stage is causing many of the mental, existential, sexual, and even physical problems we see in the clinic. It therefore seems necessary for the existential healing (salutogenesis) to take place that the therapeutic work includes early regression and healing of the traumas related to infantile autoerotism.

Ethical aspects

As so often in our life, the rule is that what we most desperately try to avoid will be our destiny. This simply follows from the way our mind works. Everything we hold on to with the mind will subconsciously direct our behaviours, also when we cling to something negative. All therapy is about telling the patient to let go of the mind clinging.

From the very beginning psychoanalysis has desperately avoided sexual exploitation of the patients. This has been regulated by firm rules of not touching and to avoid physical acting out of the sexual transference and counter transference. But sexual interest is not going away, because of such rules. And they most obviously do not prevent sex between therapist and patient, as this continues to be a huge problem, and the largest taboo among physicians and psychotherapists, whether they are classical psychoanalysts, gestalt therapist or CAM-healers.

We believe there should be firm ethical rules in therapy, but avoiding touch has destroyed the therapeutic progress. Touch is a basic human need all the way through life and in all kinds of care (58,59). Positive, accepting, pleasurable touch is most definitely needed for normal childhood development, and therefore most definitely needed as the most important part of the holding, when the patient regress to the childhood in order to solve traumatic childhood issues.

We believe that the healing of sexual traumas needs (more than healing of any other trauma) physical support and therapeutic touch. By avoiding touch in therapy in order to avoid sexual abuse, we believe that Freud and other psychoanalysts ended up with many patients being “married” to their therapist in a “sexually gratifying relationships” of little therapeutic value. The ethical problems connected with Freud’s trap are:

- The patient is deprived of her healing believing it is on its way, instead of a healing that could happen in less hours of intensive therapy involving physical touch. Therapy without touch can also be fast, if you address the issues directly, as done in short-term psychodynamic psychotherapy, where even severe psychiatric illnesses often can be alleviated in 20-40 hours (60-62) and clinical holistic medicine (53).
- The patient will be deeply involved mentally, emotionally, sexually, and existentially with a therapist for many years, often having her therapist as the closest person in her life, with him being the object of her longings, sexual fantasies, and desires. This energetic “marriage” will deprive her of the possibility of getting the male she really needs, and getting the sexual satisfaction she so separately longs for. So the patient is basically wasting her life.

Another important aspect is the question of possible financial exploitation. Independent of Freud’s trap, the use of relative inefficient therapeutically methods will always be unethical for the reasons of prolonging therapy and taking too much money from the patient. The patient eternally trapped in Freud’s trap will be caught like a mouse in a mouse trap; driven by her emotions and desires, projecting her inner male into therapist as the “divine” idealized father (or mother if a patient is having a female therapist). She will gratefully and without hesitation spend all her available money on the therapy continuing for many years, because it is just such an honour to be with the therapist for 2 or 4 hours a week - and such an Oedipal

pleasure to finally be “married to dad”. If there is no therapeutic gain and the purpose for meeting is the mutual libidinous gratification, this is very much like prostitution with the therapist being the prostituted “expert lover”. But this is not prostitution, as the therapist is not admitting – and often not even aware of - the simple, sexualised purpose of their time together. The therapist experience to work seriously; but she is just a very hard case so solve. The harder the patient’s case is, the more desperately will the patient need the therapist’s help. This necessity of prolonged therapy is not only obvious for the patient and the therapist, but often the patient’s whole social network is backing the continuation of the therapy up as extremely and vitally important; everybody is happy that the patient finally found such a brilliant doctor who really gets the therapy going. Seen by a cynical, analytic eye, the patient sitting in Freud’s Trap is caught and exploited financially; as the sexual pleasure is mutual it would not be correct to say that she is exploited sexually.

In the end of therapy there will be mourning and grief. Therapist and patient must separate, because the energy is leaving the relationship, as it always will in a sexual relationship without fundamental renewing. So the joy of therapy is converted into the pain of therapy. Much of the pleasure the patient paid for must be returned in the end, without the money being returned.

In order to sum up, the concept of Freud’s Trap is giving us a view into a part of psychodynamic therapy and psychoanalysis that is not working well. We find the reason for this to be the taboo of touch. There are many reasons for contemporary therapists not to want to touch the patients; there are restrictive therapeutic rules, there are strategies for avoid being tempted sexually, and strategies for avoiding being accused of sexual abuse. Whatever the reason for not touching is, the therapist ends up involving the patient deeply emotionally and sexually in a relationship that is supposed to be healing, but because of the taboo of touch it is not.

Such a relationship is neither truly, sexually rewarding, in spite of an often-strong focus on sexuality and some sexual gratification, nor healing. The therapist stuck with the patient ends up very much like a prostitute, with the client coming to the “expert lover” for love-sessions; but the costumers buying this kind of therapy are paying for something that neither develops into the real sex the patient is longing for, nor into the healing she actually pays for. We think that the taboo of touch is a historical mistake that prolongs therapy for years; we do not find that Freud’s Trap is causing any direct harm to the patients.

We acknowledge that psychoanalysts might disagree with our position in this chapter; we admit coming from the old tradition of Hippocratic holistic medicine, where touch has been an integral part of medicine for millennia; this gives us very different experiences than does psychoanalysis and psychodynamic psychotherapy working with all the pragmatic restrictions of the taboo of touch.

Conclusion

Sexual transference and counter-transference has been one of the large and unsolved problems in psychoanalysis and psychodynamic psychotherapy as it often makes therapy slow and inefficient, because of the mutual libidinous gratification of the therapeutic relationship subconsciously being more important than therapeutic progress. Purposeful and

expressive work on healing the patients sexuality using bodywork often takes the patient spontaneously into deep regression and all the way back to the sexual traumas in early childhood and even into the womb.

Holistic doctors have used a combination of conversational therapy and bodywork ever since Hippocrates. Freud also used intimate bodywork like massage in the beginning of his career, but stopped, presumably for moral and political reasons. In the classical tradition of psychoanalysis and psychodynamic psychotherapy touch is not allowed, especially not when related to the patient's sexuality and genitals.

Modern sexology and scientific, holistic medicine integrates, in the classical tradition of Hippocratic holistic medicine, psychodynamic psychotherapy and therapeutic touch, making it possible to support the healing of the patient's sexuality also on the physical level. Recent research in holistic medicine, salutogenesis and sexual healing has shown, that touch and bodywork is as important for healing as conversational therapy (63,64).

Holistic medicine (CHM) has also shown good results, presumably because it integrates psychodynamic psychotherapy and therapeutic touch (7,10,26,65). It thus allows the patient to spontaneously regress to early, sexual and emotional traumas, and heal the deep wounds on body, soul and sexual character from arrested psychosexual development. Modern sexology and holistic medicine treats sexuality in therapy more as the patient's internal affair (i.e. energy work), and less as a thing going on between the patient and the therapist (i.e. transference). This form dramatically accelerates healing and reduces intensity of the sexual (Oedipal) bonding between therapist and patient and as a consequence the experience of loss and need for mourning in the end of therapy.

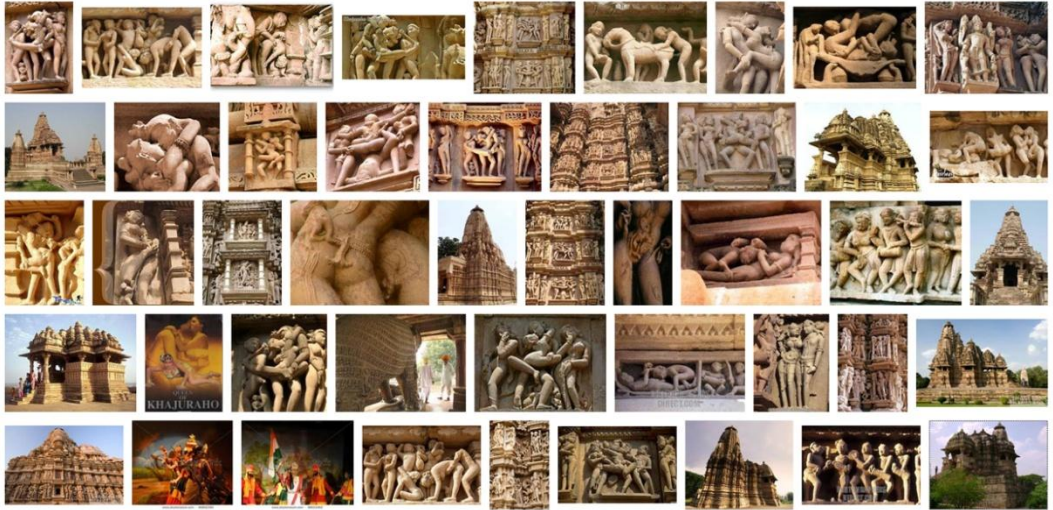
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How to use implanted memories of incest as a tool for dissolving a strong female Oedipus complex

To claim that Freud at the end of his life wanted to avoid working on the sexual traumas is to misread Freud in our opinion. On the other hand it seems that for political reasons and for psychoanalysis to survive in a period of severe critique, he choose to focus psychoanalysis on internal conflicts and not on sexual traumas. Later in his life he even admitted to have consciously repressed the fact that the parental sexual abuse of several of his female patient had created the strong female Oedipus complex that caused the hysteric and sexually dysfunctional symptoms of these patients.

As a rule such early, emotionally painful life events cannot be contacted directly by the patient's consciousness as they are deeply repressed. The way such content emerge in the therapy is by a series of fantasies or interpretations that gradually become more and more solid, until an "implanted memory" appears. This memory is not at all accurate, but carries the part of the emotional content of the trauma that the patient can tolerate. As therapy progresses this "implanted memory" will transform into a true recollection of the actual traumas. "Implanted memories" can therefore be an important tool in the sexological clinic.

Sometimes the abuse of the child was physical, but as often it was psychological (energetic incest). If the process of healing continues to its natural closure, the patient will know with certainty what actually happened at the end of the therapy.

Introduction

In the ongoing debate on implanted memories and sexual traumas (1-3), Robert Withers (4) pointed out that it is possible to use memory defensively to evade uncomfortable feelings in the transference, and similarly possible to use the transference defensively. So we are in great trouble as therapists, when we want to be sure that what we are dealing with is based on reality and not on defensive construction.

It seems that Freud for political reasons and in order for psychoanalysis to survive in a period of severe criticism, choose to focus psychoanalysis on internal conflicts and not on sexual traumas. Later in his life he even admitted to have consciously repressed the fact that the parental sexual abuse of several of his female patients had created the strong female Oedipus complex that caused the hysteric and sexually dysfunctional symptoms of these patients (5,6). It is not difficult to understand why Freud chose this path, away from conflicts that easily could have put psychoanalysis in a bad position. We have learned from the way the brilliant researcher Wilhelm Reich (7), the founder of modern sexology, was treated with persecution, imprisonment and public book burning, that Freud choose a wise route for psychoanalysis, when he avoided the hot issues, which could explode in the media. All readers of Freud will know how often Freud addressed this political level and how thoroughly he incorporated it when he developed psychoanalysis.

But time is no longer for hiding the truth and being political; we need a science of therapy that works and effectively will cure our patients. Robert Withers (4) is correct when he states that the sexually traumatised patient that hear her analyst saying in essence: 'Let's not talk about your father raping you—let's talk about us' is severely let down by her therapist. He concludes: "There is no doubt that at times the transference/counter transference can be a wonderful therapeutic tool. But we do our patients a disservice, if we forget Freud's original insight that it can also be used by the resistance—especially in the face of emerging traumatic material."

We would like to take this a bit further. We want to state that implanted memories of incest can be a wonderful tool also, if the energy of this false memory comes from a strong, un-dissoluted female Oedipus complex. One can ask: How can such a fixed energy most easily be dissolved? What is the most direct route? Basically the female Oedipus complex is the girl's sexual energy directed towards her father and because of the taboo of incest denied and repressed.

So the most direct route is to visualise the intercourse with the father in order to free the energy. But we all know that the superego, because of the incest taboo, will not allow such a fantasy. But if this enters as an unconscious, implanted memory of sexual abuse or rape, this problem is solved. Now the problem is how to own and integrate such a forbidden gestalt. If the therapist and the patient simply allows this to be explored in a non-judgemental atmosphere, the emotional charge will slowly be taken out of the gestalt and set free to be used by the woman in her adult relationships.

Interestingly, the mention of the Oedipus complex as a possible real intercourse with the father is taking much of the sexual charge out of the transference-counter transference dynamic, making this a much faster route to sexual healing and re-sexualisation of the woman, than the traditional psychoanalytic method of addressing everything as transference.

We even suggest that some women are unable to process and heal all the way to mature genital sexuality, if their Oedipus complex is not treated like it was caused as an actual, sexual trauma.

This is most definitely the case, when the patient actually was sexually traumatised, for without the full integration of the trauma there will be no complete healing. This is also the case when the Oedipus complex is caused by symbolic abuse, i.e. where a father psychologically has substituted a mother with a daughter, which is quite normal, i.e. when the mother dies, is divorced from the father, or just leaves the home for a longer period of time.

Eight causes of implanted memory

The eight most common causes of implanted memories are (8):

1. *Satisfying own expectancies*: If the patient expects that she had been abused sexually i.e. because a sister was, she can implant more or less vague memories of incest herself.
2. *Pleasing the therapist*: The patient wants to please or be in accordance with the therapist and is therefore accepting his view or what she believes or imagine is his view. This is enhanced if the therapist shares his interpretations and give the patient leads (i.e. questions that are not neutral, but biased in some direction). Even more so, if the therapist is making judgments on what happened instead of waiting until the patient finds out for herself.
3. *Transferences and counter transferences*: If the patient develops sexual feelings towards the therapist and if these are ignored by the therapist, or if the patient senses that the therapist will not accept them, this can enhance sexual fantasies, which eventually can take the form of an implanted memory. Old sexual fantasies can also be boosted by this unconscious wish of the patient, and even real events can be distorted, reinterpreted and now filled with the sexual feelings that the patient cannot allow to emerge in the personal relationship with the therapist.
4. *As source of mental and emotional order*: A third source of implanted memories has nothing to do with the therapy in itself. The patient needs to get a kind of order in the chaos of emotions and symptoms, and having a simple explanation can be a relief instead of living with chaos and mystery.
5. *As emotional defence*. Sometimes the recovered, but false memory is hiding another event that is much more painful. This could be that her father left her and her mother, when she was a child. This may be much more difficult to integrate than sexual abuse. If the patient is desperately angry with her father and cannot confront the event causing the anger, an implanted event can be a solution. It could also be neglect that is the problem; it seems that neglecting the bodily presence and sexual character of a girl can be as destructive to her self-esteem and psychosexual development as actual physical or sexual abuse.
6. *As symbol*. Often, the parents have been abusing the child in subtle and psychological ways, (i.e. not respecting the child's sexual borders, or having used the child as a sexual partner, which is most often seen when a parent lives alone with a child of the opposite sex). This does not mean that there was a sexual act of objective, physical, incest like coitus, but what we could call the "symbolic incest" or "energetic incest" is often extremely painful and very harmful to a child on an emotional level. "Energetic" incest happens typically when her father being the only parent raises a girl (or when a mother raises her son alone), and the two of them "pair up" as man and woman making wholeness emotionally and energetically comparable to the wholeness of a sexual couple, but without the sexual acting out. A lot of sexual energies are accumulated and circulated here, and the girl is often, as Freud pointed out, having secret sexual dreams about her father with lots of shame and guilt. An implanted memory that carries all the shame and energy of a real incestuous trauma,

but where intense therapy did not reveal any recorded “movie” of the event(s), might very well come from “energetic incest”.

7. *Implanted philosophy.* When a patient learns that problems often are caused by traumas, she often starts speculating which traumas could have caused which problems. Sexual problems can then lead to dreams about sexual dominance/abuse/perversions and dreams, which can be interpreted as memories. Freud taught us that the child’s sexuality is polymorphously” perverted, meaning that all kinds of sexuality is present at least potentially with the little child. In dreams, according to Freud, consciousness often goes back to the earlier stages of development, potentially leading to all kinds of sexual dreams and fantasies.
8. *Implanted memories function as the patient’s subconscious tool for sexual healing.* When a patient has a very strong Oedipus complex and not willing to take this to transference and prefer to handle it psychologically as an internal affair, this will materialize as a visualization of intercourse with the opposite-sexed parent. This as the incest-taboo will make it impossible to accept the fantasy in present time and therefore it will materialize as a false memory of physical sexual abuse. Only if this memory is acknowledged and taken seriously, the Oedipus complex will dissolve; in this process the patient will realize the true nature and mission of the “implanted memory”.

Different opinions of Freud

It is worthwhile to give the word to Freud himself, who wrote: “In the period in which the main interest was directed to discovering infantile sexual traumas, almost all my female patients told me that they had been seduced by their father. I was driven to recognize in the end that these reports were untrue and so came to understand that hysterical symptoms are derived from fantasies and not from real occurrences. It was only later that I was able to recognize in the fantasy of being seduced by the father the expression of the typical Oedipus complex in woman” (6).

Anna Freud reflects on this passage as follows: “In his early discussion of the etiology of hysteria Freud often mentioned seduction by adults as among its commonest causes. But nowhere in these early publications did he specifically inculcate the girl’s father. Indeed, in some additional footnotes written in 1924 for the *Gesammelte Schriften* reprint of *Studies on Hysteria* he admitted to having on two occasions suppressed the fact of the father’s responsibility” (6:419).

Conclusion

Where does this take us? To the practical position, where we should be willing to do what it takes to cure our patient. Every therapist should know that a patient’s memories are not accurate, and at the start of therapy the “memories” are much more like guessing or diffuse interpretations than visual and tactile accurate recallings.

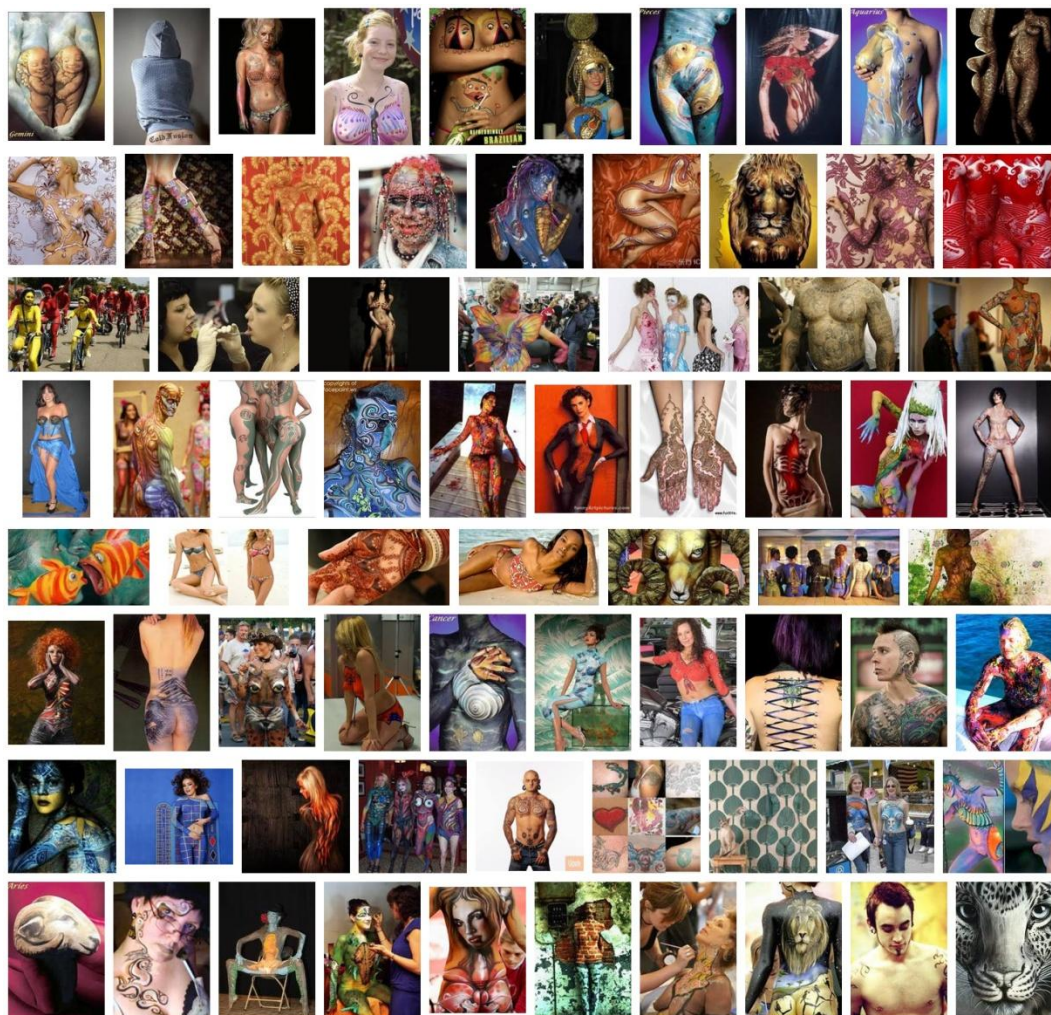
There should be plenty of room in the therapy to allow the patients all kinds of “memories”, fantasies, ideas and mental and emotional experiments. The therapist should keep the patient safe by securing that she is not sharing her ideas with her parents etc, as long as the therapy is not completed and her Oedipus complex not dissolved.

If the “implanted memory” or more correctly put “visually false but emotionally correct memory” is taken as a powerful therapeutic tool instead of something that should be avoided at any price, the patients will heal and become sexually mature at a much higher speed and success rate, than if the therapist and patient is avoiding the core issue from fear of the possibility of making an implant. In the end of the therapy the patient will know exactly what happened.

The art of therapy is to keep the patient on the right track of facing all resistance and difficult emotions, following her all the way through the dark night of the repressed and unconscious, and into the dawn of the bright day of mature sexuality, unconditional love, and mental and existential freedom.

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Holistic approach to rape and incest trauma

Studies indicate that at least 15% of the female population in western countries have experienced sexual abuse and severe sexual traumas. In South Africa in a recent national survey one man in four admitted having committed rape at some point in time, so in many parts of the world rape is very common. Systematic rape of the enemy's women, and even of teenagers and children, are often part of war. Often war rape is done with the most extreme cruelty, with severe lesions on the genitalia. Sometimes reconstructural surgery is necessary i.e. to close ano-vaginal fistulas after violent penetration with alien objects. These rape cases teach us the depth and severity of the human shadow discussed in the previous chapter on pleasure and pain in sexuality.

This chapter explains how even serious sexual abuse and violent sexual traumas can be integrated and healed, when loving care and sufficient resources encourage the patient to return to the painful life events and eventually heal. When the physician cares and receives the trust of the patient, emotional holding and processing will follow quite naturally, and small miracles will often follow. Even scars and other physical problems will often also be smaller and less burdensome in this process.

Spontaneous regression seems to be an almost pain free way of integrating the severe traumas from earlier experiences of rape and incest. This technique is a recommended alternative to classical timeline therapy using therapeutic commands.

When traumatized patients distance themselves from their soul (feelings, sexuality and existential depth), they often lose their energy and enjoyment of life. But this does not mean that they are lost to life. Although it may seem paradoxical, a severe trauma may be a unique opportunity to regain enjoyment of life.

The patient will often be richly rewarded for the extensive work of clearing and sorting out in order to experience a new depth in his or her existence and emotional life with a new ability to understand life in general and other people in particular.

So what may look like a tragedy can be transformed into a unique gift, if the patient gets sufficient support, there is the possibility of healing and learning. Consciousness-based medicine seems to provide the severely traumatized patient with the quality of support and care needed for the healing of body, mind and soul.

Introduction

The problem of victimization and re-victimization is psychologically extremely complex. Most people believe the victim is chosen randomly by the offender, but research has shown that victims very often have been victims before and that victimization is a long chain of life events containing many different objective events, but they are the same mode of victimization.

Russell (1,2) found that between 33% and 68% of the sexually abused victims were subsequently raped. This is compared to an incidence of 17% for non-abused woman. Other researchers (3) have found that 18% of repeat rape victims had incest histories, compared to 4% of first time victims.

The research indicated that for many rape victims, who have been victimized before, the rape and sexual assault are seldom accidental. These events follow a dark and sad pattern of unconsciously replaying and reliving the role of the victim. This makes the therapy of the rape and incest victim complex. Most rape victims have earlier incidents of victimization and most incest victims have had difficulties with keeping their boundaries and taking care of their personal safety.

As sexual assaults and rape is among the life events with the most dramatic negative effect on quality of life, the physician must take such traumas extremely seriously. Unfortunately, such sexual assaults are fairly common in the population. Studies from different western countries indicated an incidence of about 15% of the girls being assaulted sexually in childhood (1,4,5). These patients are also more likely to be physically abused by husbands and partners (1,6). Unfortunately some are even abused by the therapist, who was supposed to heal and protect them (7).

Poor quality of life is statistically connected to bad health. About one in four of the patients seen by the family physician will have such highly painful histories. Most of these sexual traumas remain hidden. The work with these serious problems can therefore not be a task for specialists. Every physician must be able to handle these traumas, when met in the clinic.

Fortunately, the loving and caring physician or sexologist, using the tools and principles of modern sexology and scientific holistic medicine (8-16), can help the patients to heal, even with serious wounds on the body and soul. In this chapter we discuss the general principles of holistic and sexological treatment of incest and rape victims.

Therapy with incest and rape victims

Many forms of therapy have proven effective with rape victims, like cognitive-behavioural therapy (17-19), reality therapy (20) and group therapy (21). Many forms of therapy has also proven effective with incest victims, like play therapy (22), analytical psychotherapy (23), supportive group therapy (4,8,24,25), couples therapy (26) and family therapy (27), but as shown by Krach and Zens (7) the result of the therapy is often not completely satisfactory. This is in part because the ethical standards of the therapist working with the incest victims have often been regrettably low. 46% of the incest victims feel abused after the therapy, (sexually or otherwise). The toolbox of holistic medicine includes an ethical strategy

(“coming from the hearth”) (29), which it intended to eliminate the possibility of such malpractice in the holistic medical clinic.

Holistic trauma treatment: The use of spontaneous and guided time line therapy

When we feel that we have lost our value as human beings (as many girls do following a sexual assault), or when we feel that our manhood and self-confidence have been seriously damaged, (as many men do following a violent assault) a destructive decrease in self-esteem and self-confidence will result. This is often due to the decisions made during or after the incident to overcome the unbearable feelings of fear, shame, guilt, powerlessness and hopelessness. Holistic treatment of the after-effects of sexual and/or violent traumas is important in order to work on the mind-body dissociation (27), post traumatic stress, self-blame, sexual dysfunction and low self esteem. Holistic treatment in this case is based on classic time line therapy, going through the incident over and over again, until the patient clearly acknowledge what happened then and can let go of the negative decisions, made in the heat of the moment.

First the patient has to feel the pain once again and then everything will be understood. Ultimately, the victim can let go of the life-denying decisions and will feel as though the incident never occurred. Very often the whole chain of similar events must be processed, to cure the symptoms. Often this will require thorough and time-consuming work which gives the patients an important learning experience. Relief from the painful events and often even a gratitude that it happened that an old, self-destructive pattern finally can be broken.

Aldous Huxley’s novel, *Island* (30), provide a beautiful description of time line therapy. Sending the patient back to the trauma can be done by means of the classic time line commands, if the physician has gotten the full trust and acceptance by the patient to receive the necessary holding (awareness, respect, care, acknowledgment, and acceptance) (31):

1. Go back to when it happened.
2. With your eyes closed, go through the event from the beginning to the end.
3. Tell me what happened.

This process should be repeated until the problem has been processed, the learning gained, and the pattern broken. Despite the simplicity of the commands, time line therapy is not a simple process. Indeed, the skilled time line therapist must be able to identify the patient’s position on the time line at any time. Also, the experienced therapist rarely needs to apply time line therapy at all. Meeting and joining the patient exactly where she is will send her back in time spontaneously. To be more exact: the patient has never moved beyond the frozen now (and the time of the trauma). So the good doctor should simply join and support the patient with the intention of helping her and then the patient will regress spontaneously – or to be precise- the patient will confront the pain in the frozen now.

In our opinion, therapy with many mental commands is therapy that tries to process things without the requisite emotional holding. In our view, love and compassion constitute a much stronger therapeutic strategy than using power and mental guidance. The former is holistic and practical, the latter keeps within the framework of the mind. From our perspective, Neuro Linguistic Programming (NLP) and mental processes of that kind are not holistic therapy. With love and compassion, holding and processing can come quite naturally and thus result in holistic healing.

Modern holistic medicine and sexology

The major difference between classical holistic medicine and sexology and its modern counterpart is the theories used by the latter. The belief is that nothing is as practical as a good theory and from this philosophy a number of new theories for existential healing and holistic therapy have emerged. These theories of healing are not substituting Hippocrates original theory of repression of the human character as the primary cause of all physical, mental, existential and sexual problems, but elaborates on the aspects, where Hippocrates and his students were less clear.

The life mission theory (31-36) states that everybody has a purpose of life, or huge talent. Happiness comes from living this purpose and succeeding in expressing the core talent in your life. To do this, it is important to develop as a person into what is known as the natural condition. This is a condition where the person knows himself and is able to use all his efforts to achieve what is most important for him. The holistic process theory of healing (37-40) and the related quality of life theories (41-43) explain that the return to the natural state of being is possible, whenever the person gets the resources needed for the existential healing. The resources needed are “holding” in the dimensions of awareness, respect, care, acknowledgment and acceptance with support and processing in the dimensions of feeling, understanding and letting go of negative attitudes and beliefs.

The preconditions for the holistic healing to take place are trust and the intention of the healing to take place. Existential healing is not a local healing of any tissue, but a healing of the wholeness of the person, making him much more resourceful, loving, and knowledgeable of himself, needs and wishes. By letting go of negative attitudes and beliefs the person returns to a more responsible existential position and an improved quality of life. The philosophical change of the person healing is often a change towards preferring difficult problems and challenges, instead of avoiding difficulties in life (44-51). The person who becomes happier and more resourceful is often also more healthy, more talented and more able to function (52-55).

Acute trauma

Female, aged 34 years with acute trauma.

Arrives in a state of shock and on the brink of tears after having a street fight with her former husband and having had her life threatened by him. He is now on the run from the police, as he has a suspended sentence. She has sent her two children of 5

and 10 years to stay with relatives and friends. Needs psychological assistance, perhaps one weekly session for eight weeks. Sick leave for three weeks. Prescribe urgent counselling – the incident is reviewed four times here, until the patient no longer cries, when confronting it. The psychologist should take over from there.

We refer the patient to a psychologist or a gestalt therapist, but cannot send her home, as she is completely emotionally incoherent. We relieve the pressure by means of simple time line therapy. The patient goes through the incident until the intense emotional reaction has worn off. In this case, the psychologist is also needed because of the social circumstances. Successful trauma therapy is about keeping patients in the present, while their attention moves back in time and confronts the traumatic events. Difficult feelings, which the patient receives insufficient support in facing, will allow her to let go of the present and return to the past. Without contact with the present the patient is technically psychotic and the therapeutic gain from the session will be negligible.

An experienced holistic therapist will notice that the patient is about to lose her mental focus (“third eye closing”), before she has left the present. In this situation we would quickly call in another therapist to support the patient. A patient, who is on the brink of psychosis on arrival has to receive ample support, for instance in the form of a “good father” and a “good mother”, before the therapeutic process can begin.

Traumas in body and mind

The classic trauma is a serious and unexpected assault such as rape. In a holistic perspective, even in the case of atrocities, most injuries to the body and mind can heal,

Female, aged 16 years and raped.

In the train, a 16-year-old girl noticed that a young man has taken an interest in her. She avoided his glance, but as she gets off the train on a dark road, he follows her. She becomes scared and tries to run away, but he catches her, throws her to the ground and rapes her. It hurts and she is very frightened. “If you tell anybody, I’ll kill you,” he whispers to her. She tells no one, but her friends notice that she has become quieter. Once she managed to let go of the sentence “He’ll kill me” during therapy, she brightened up and returned to her old self.

This girl has been marked by the incident. The question is why events affect individuals so differently, and what actually takes place when we are injured by a trauma. Exactly what was it about the rape that traumatised her? Suffering inflicted on us by the trauma itself, however unpleasant in the present, does not seem to harm us subsequently – unless we repress the suffering in the situation and consequently carry it with us. Thus, pain is not traumatising in itself. Whether or not we become traumatised depends on how we relate to the pain. In the specific situation, the victim can repress the unbearable emotional pain for which she cannot assume responsibility. By drawing a justifying conclusion she makes the pain go away and consequently enables her to cope with the situation. But although the pain has disappeared from her conscious mind, it still exists below the surface. After the event, she now carries it along with her. The statement “He’ll kill me” is impressed on her subconscious mind and she now has an impression of men that will restrain her in future, until she relives the pain by

being a victim during therapy. In this way she chooses to suffer without resistance and makes her mind let go of the statement. For lack of a better expression, we call such statements which are generalised justifications enabling us to disclaim an unbearable responsibility, “decisions”.

Early sexual abuse

Early sexual abuse is often extremely traumatising and the girls, who are most frequently the victims, end up making numerous self-destructive decisions, which are very difficult to become aware of and let go of. But as the victims address the pain and fully understand the assaults and their nature, they can let go of the negative decisions and life returns. We believe that holistic medicine, when used correctly, can be so effective that no serious scars remain on the soul... The patient can achieve complete recovery, but it takes love and care. Holistic therapy alone is not enough.

Female, aged 21 years and sexually abused.

First quality-of-life (QOL) session: Wants to resolve her inner existential problems that peaked after she had helped a friend recover from a suicide attempt. Has a very difficult personal history, but has tackled it surprisingly well. Has very strong defences, enabling her to appear as a smart and sensitive young woman. SOCIAL: Both parents alcoholics, she lived in a foster home when she was young, was adopted by a couple who divorced four years later, new father also an alcoholic, died when the patient was 9 years old. Subsequently, she lived with the mother of her adoptive father, who ignored her. At the age of 12 years she asked to be placed in a foster home, where she stayed for one year, but the foster family was psychologically mean to her and she felt like a prisoner. Moved to a student hostel on her 18th birthday. On examination: On the couch, however, it can be seen that from the chest down she is practically dead – her abdomen looks more like the abdomen of a corpse, all pale, devoid of blood and life. Strange damage on the skin of both hips, like the cracks in the dermis layer normally seen in pregnant or obese women, but the patient was never overweight. Previous assessment for this, no conclusion. SUBJECTIVE FINDINGS: We talk about emptying the internal waste bin and she appears to be clear and determined about her personal development project: The aim is to find out what you want to do with your life. She wants to provide care, but that is an understandable reaction to her life. Should rather grow up and become independent. She has had about four boyfriends. Her self-esteem needs to be restored. Deserted repeatedly in her life, so she needs to reopen her heart. EXERCISE: Write down your life story – focus on your feelings, thoughts and decisions. Start from the present. What happened? How did you feel? (What decision/conclusion did you make?) What happened? How did you feel? Topics: friendship, love, sex, food, failure – school/work, family, leisure-time. Next appointment in two weeks.

Second QOL session: Has been well, has been very much at home in her abdomen and has felt more than she used to since last session. Has done her homework nine months back. We look at it together. She does not write as much about her feelings, as I (SV) would have liked, it is as though she finds it difficult to recall her feelings. We work on that. EXERCISE: Make friends with your body – do some sport, possibly together with other people, cook some nice meals for yourself, preferably three times a day, explore your sexuality and get to know yourself better, also inside

the pelvis and abdomen. EXERCISE: When you continue your autobiography, take the emotional perspective. One hour a day at the most, opens up and then closes. Next appointment in two weeks. Should come sooner if she suddenly feels bad. I think therapy will be hard on her.

Third QOL session: We talk about what theme she is dealing with in her current process. Something about playing dead to survive some horrible situation. Has met a 24-year-old man, whom she has had sex with. The relationship is good. She can feel her emotions. She seems relaxed and happy, and is going camping in the summer and will take our summer course, Life Philosophy that Heals. Should continue the exercises from last session.

Fourth QOL session: Fourth QOL session: Attended the course Life Philosophy that Heals (life purpose: I am wise.) She relived the extensive sexual abuse that she experienced as a child when she was about three years old. Has cried for hours and felt a terrible pain in her reproductive organs and abdomen.. Attended the course Life Philosophy that Heals (life purpose: I am wise) and has relived extensive sexual abuse as a child when she was about three years old. Has cried for hours and felt a terrible pain in her reproductive organs and abdomen... Today she feels much more alive and energetic, and she looks much better, although she still has the habit of “playing dead” – she gives, but does not take from her boyfriend, whom I believe she really needs. She has close friends, but she shares only a small part of her life with them. EXERCISE: Rely more on your friends: give and take –take the initiative to be with them, frequently and intimately. Make use of your sexuality. Feeling EXERCISE: Sit on a chair for five minutes every day and sense how you feel. She already does that exercise. How to become truly wise and smart? Write two A4 pages about it. You are going at 1 km/h – it’s time to speed up!

Fifth QOL conversation: Things are going well – has set her boundaries with her supervisor, has attained self-respect and her own space. Has experienced close contact with girlfriend. Feels buoyant and happy today. She has reflected sexuality, no problems there, she believes. 1. Rely more on your friends: give and take – and take the initiative to be with them, frequently and intimately – OK, she has done that. 2. Make use of your sexuality– OK about herself. Feeling EXERCISE: Sit on a chair for 5 minutes every day and sense how you feel. She is already doing that - OK. EXERCISE: How to become truly wise and smart? A two-page draft – she has not done that – for next time – write down all sub-aspects you can find of “knowing”.

This patient will have to work on herself for years in order to heal the early damage from sexual abuse. Perhaps her wounds will not heal completely, until the day she finds herself in a warm and genuine relationship.

Discussion

It is not always possible to work on a certain event in life during therapy. Sometimes the event is thoroughly repressed, even though well-defined symptoms may have begged the patient to deal with it. Often, the reason for this is that the traumatic event is not a singular event, but occurred as follow-on from earlier traumas and life-denying decisions.

Indeed, in our culture it is common to have experienced a handful or more traumatic events that are related to our problematic themes in life, as mentioned previously. The reason why the individual trauma, which need not be particularly severe, may tip the balance is its contact with earlier, underlying traumas in the particular situation, reactivating their painful

content. Most people believe that the anxiety, pain, shame and hopelessness, come from the most recent event. The most recent events have much deeper and more serious roots.

The patient has to reconsider his entire life philosophy and large parts of his personal history in order to regain his balance. The patient needs to be relieved of what may appear, in retrospect, to be a considerable amount of naivety and shallowness. Not until the patient has developed and raised his personal level of responsibility can he integrate the underlying traumas. The patient is now facing two choices: To shut off emotionally and survive, perhaps sustained by symptom-relieving medication such as antidepressants, or to give life a thorough clean up. With love for our patient comes trust, holding and processing and results in holistic healing. Instead of giving commands, giving a surplus of care and resources invites the patient to spontaneously return to the painful events of life. Spontaneous regression seems to be an almost pain free way of integrating even severe traumas, like the traumas that result from rape or incest (affecting at least 15% of the population) (1,4,5). Interestingly, most of the incest traumas remains hidden in the biomedical clinic, but are often revealed in the holistic clinic, where love or professional care and intimacy is an important part of the therapy. When traumatized patients distance themselves from their soul, feelings, sexuality, and existential depth, they can easily lose their energy and enjoyment of life. But this does not mean that they are out of the game of life. Although it may seem paradoxical, a severe trauma may be a unique opportunity to gain new understanding and regain participation and full enjoyment of life. The patient will often be richly rewarded for the extensive work of clearing and sorting out and will often experience a new depth in his or her existence and emotional life with a new ability to understand life in general and other people in particular.

So what may look like a tragedy in the beginning of the therapy can be transformed into a unique gift. If the patient receives the sufficient support there is a possibility of healing and learning. Consciousness-based, holistic medicine and sexology seem to provide the severely traumatized patient with the quality of support and care needed for their soul and deepest existence to heal.

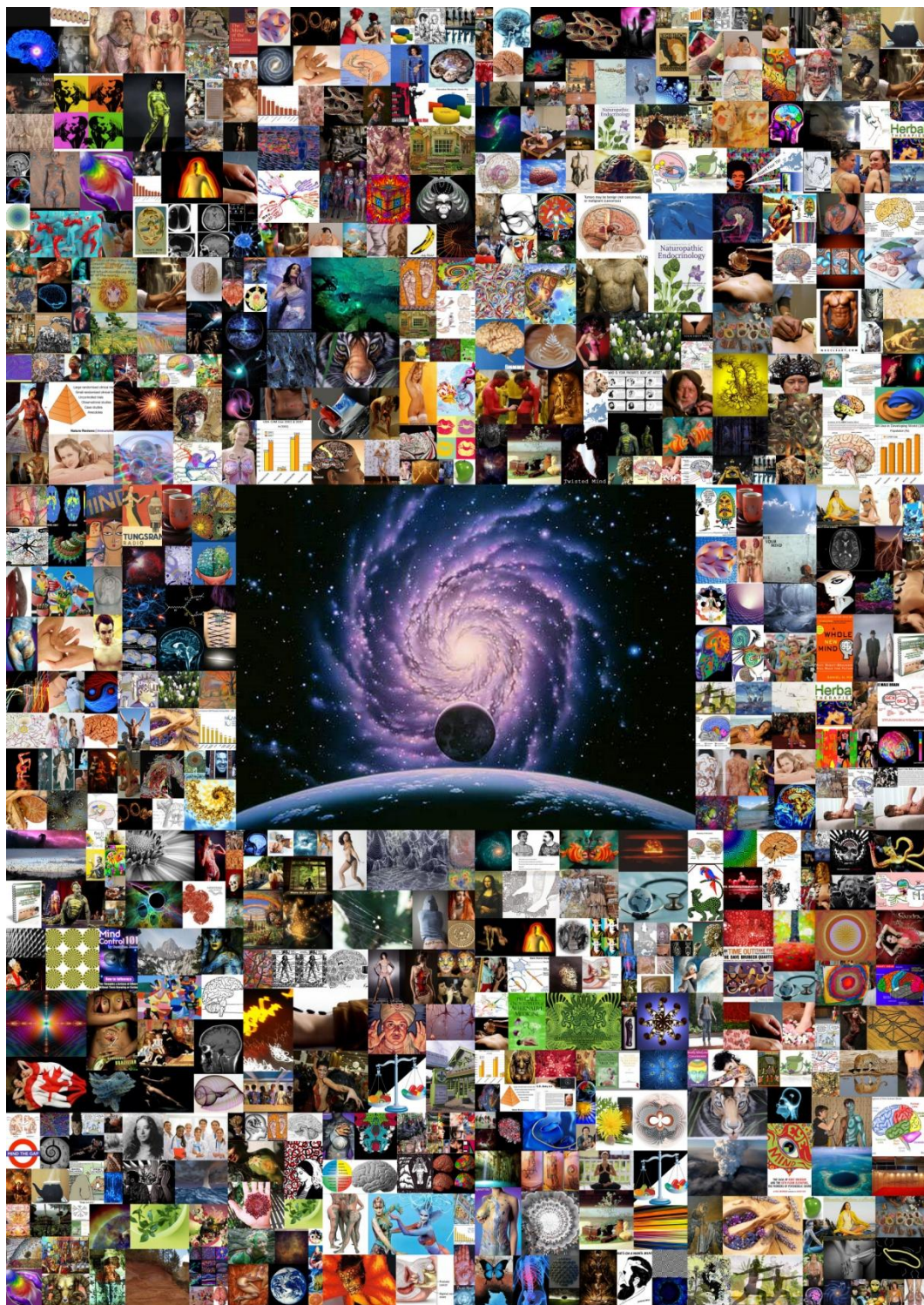
The most important prerequisite for the healing to happen is the physician's or sexologist's love or care for the patient and every physician with a loving heart can learn to use the holistic medical toolbox and thus help his patients to heal existentially.

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Long term effect of child sexual abuse and incest with a treatment approach

The nervous breakdown of a 22-years old young woman was caused by severe sexual abuse in childhood repressed over many years. During the therapy the patient accumulated resources to start the painful integration of these old traumas. Using holistic existential therapy in accordance with the life mission theory and the holistic process theory of healing, she finally was able to confront her old traumas and heal her existence. It seems she recovered completely, including regaining full emotional range, though holistic existential therapy, individually and in a group therapy. The therapy took 18 month and more than one hundred hours of intensive therapy. In the beginning of the therapy, the issues were her physical and mental health, in the middle of the therapy the central issue was her purpose of life and her love life and at the conclusion the issue was gender and sexuality. The strategy was building up her strength for several months, mobilising hidden resources and motivation for living, before the old traumas could be confronted and integrated. The therapy was based on quality of life philosophy, on the life mission theory, the theory of ego, the theory of talent, theory of the evil side of man, theory of human character and the holistic process theory of healing. The clinical procedures included conversation, philosophical training, group therapeutic tools, extended use of therapeutic touch, holistic pelvic examination and acceptance through touch was used to integrate the early traumas bound to the pelvis and scar tissue in the sexual organs. She was processed according to 10 levels of the advanced toolbox for holistic medicine and the general plan for clinical holistic psychiatry. The emotional steps she went through are well described by the scale of existential responsibility. The case story of Anna is an example of how even the most severely ill patient can recover fully with the support of holistic medical treatment, making her feel, understand and let go of her negative beliefs and life-denying decisions.

Introduction

The scientific breakthrough in the understanding of human sexuality, still a most central theme in the clinic of the general practitioner (1), came with Masters and Johnson's brilliant

work in the middle of the last century (2,3). The most famous curve in sexological research is still the curve of the male and female sexual reaction cycles, explaining the four phases of the normal sexual intercourse: the excitement phase, the plateau phase, the orgasmic phase and the relaxation phase.

Since their work, most clinical sexologists have recognised a pre-phase of lust, where one of the most dominant problems of our time is the lack of sexual lust in the female (4). We have recently presented a theory of sexuality that can serve as guidance for the holistic sexologic therapy (5), especially when we want to treat the whole person and overview all the relevant dimensions of sexuality and existence.

We want our patient to be a whole, balanced, ethical and able person, not just to be able to function sexually. In our work with sexually abused patients we have often found that severe mental disturbances and even insanity can follow directly from sexual abuse.

As sexual and existential problems often go hand in hand and as both existence and sexuality are theoretically difficult issues, the two maybe most fundamental questions of the research in human life and quality of life are: “what is existence?” and “what is sexuality?” Often the first question is left unanswered and the second met with theoretical answers from evolutionary theory and psychosocial models (6,7), but very difficult to use in the holistic sexological clinic. The following case story shows how a combination of holistic sexology, holistic psychiatry and advanced holistic existential therapy can be used to treat even the most severe cases of sexual abuse. We use the strategy for spontaneous regression in the holistic healing of patients with incest and rape traumas (8). The patient was treated in accordance with the 10 steps of the advanced holistic toolbox (9).

Anna was a student aged 22 years, who had completely repressed over 100 episodes of sexual abuse, incest and rape throughout her early childhood (10). She now seems to have recovered completely, inclusive regaining her full emotional range, though holistic existential therapy, individually and in a group. The therapy took 18 month and more than one hundred hours of intensive therapy. In the beginning of the therapy, the issues were her physical and mental health, in the middle of the therapy the central issue was about her purpose of life and her love life. In the end of the therapy the issue was gender and sexuality.

The strategy was building up her strength for several months, mobilising all her hidden resources and motivation for living, before the painful old traumas were confronted and integrated. The therapy was philosophically based on quality of life philosophy (11-18) and theoretically based on the life mission theory (19), the theory of ego (20), the theory of talent (21), the theory of the evil side of man (22), the theory of human character (23) and the holistic process theory of healing (24-26), all of which she became familiar with during the therapy.

The clinical procedures included conversation and philosophical training and the group therapeutic tools. Extended use of therapeutic touch, holistic pelvic examination (27) and acceptance through touch (28) were used to integrate the early traumas bound to the pelvis and scar tissue in the sexual organs.

She was processed according to the general plan for clinical holistic psychiatry (29,30) and the steps she went through are described by the scale of existential responsibility (the Responsibility-for-Life Scale) (30).

The four fundamental steps of healing were: 1) loving her (or in other words intense care for the patient), 2) winning her trust, 3) getting permission to give her holding and support

and 4) re-parenting, allowing her to be a child again, to feel, understand and let go of literally hundreds of negative, life-denying decisions (19,31,32).

Her case is a fine example of the power of healing with the holistic existential therapy. It describes the dangers and problems of working with love and intimacy with the sexually abused patient, but also the huge value of holistic gynaecology and sexology in this situation (4,28,33).

Modern holistic medicine and sexology

The life mission theory (19-23,34,35) explains that everybody has a purpose of life, or huge talent. Happiness comes from living this purpose and succeeding in expressing the core talent in life. To do this, it is important to develop as a person into what is known as the natural condition, a condition where the person knows himself and use all efforts to achieve what is most important for him.

The holistic process theory of healing (24,25,36,37) and the related quality of life theories (38-40) states that the return to the natural state of being is possible whenever the person gets the resources needed for the existential healing. The resources needed are holding in the dimensions: awareness, respect, care, acknowledgment and acceptance with support and processing in the dimensions: feeling, understanding and letting go of negative attitudes and beliefs.

The preconditions for the holistic healing to take place are trust and the intention for the healing to take place. Existential healing is not a local healing of any tissue, but a healing of the wholeness of the person, making him much more resourceful, loving and knowledgeable of himself, his own needs and wishes. In letting go of negative attitudes and beliefs the person returns to a more responsible existential position and an improved quality of life.

The philosophical change of the person healing is often a change towards preferring difficult problems and challenges, instead of avoiding difficulties in life (11-18). The person who becomes happier and more resourceful is often also becoming more healthy, more talented and able of functioning, mentally, emotionally, physically, sexually and spiritually (26,41,42).

The story of Anna

The struggle of an abused young girl for love and sanity. Sometimes there is a particular chemistry between the patient and the therapist enabling the patient to get released from even very serious circumstances. The story we are going to tell is one of the most intense and dreadful stories we have yet experienced in the Research Clinic for Holistic Medicine in Copenhagen and at the same time the most beautiful and accomplished treatment we have given.

There were three major difficulties in the cause of the therapy. In the beginning it was extremely difficult to win the trust of this patient and only after months of therapy was this accomplished. Then, since her resources were so small and only after she was supported by a whole group of people (the group level (26) or the "level 5 of holistic medical tools" (9))

could she confront the real cause of her mental and emotional problems, namely the repression of years of brutal sexual abuse in her childhood by three different men at age 2-7 years.

We are not able to tell for sure, if these events really happened to Anna, since she decided not to confront her family with her findings in the therapy. But from the emotional intensity of the traumas and from the immense healing she got from integrating them there can be little doubt that these events actually happened or that something quite similar happened to her. The time for the onset of the abuse could be much later than the age of two she recalls, but again seems the state of mind she entered during the therapy to be the state of mind of a very little child, so while we cannot put an exact objective date on the events, there is congruency between her rapport and our observations during the therapy. All in all we find reason to believe that the story of Anna is a true story, and that her recollections of violent and sexual abuse from her early childhood were accurate.

When trust and intimacy finally was established in the group setting the patient was regressing so intensively into old painful wounds of sexual abuse that she almost lost her mind and entered into a psychotic paranoid state, which took intensive resources over a month to heal with extensive use of the strategies for healing mental disease with holistic therapy (29,30). In the end of the therapy, separation between patient and physician was emotionally difficult and in the end she felt somewhat rejected. To help this extraordinary wounded patient most of the more complex concepts of holistic medicine, including holistic rehabilitation, holistic sexology (4,28) and holistic psychiatry were used. Surprisingly, there were no traumas, even the most brutal, that could not be healed completely in the holistic existential therapy.

Physician's rapport

The patient was a beautiful, slightly chubby 22 years old woman of average height, that we will call Anna. When she came to consult our clinic the first time, she was a student at the School of Education. She had started to get uncontrollable weeping outbursts for which she could not give any reason herself. Furthermore, she suffered from a low back condition, possibly a slipped disc of earlier date, which caused her much pain. She had also sexual problems. It was as if her life was going to overturn mentally, her zest for life diminished more and more and had nearly disappeared. Her confidence in other people drastically diminishing, her contact to the outside world became more and more moderate and her thoughts got ever more strange. Most of all it seemed beginning schizophrenia. It was not easy to say into what her illness would have developed, if not treated. Her condition was not steady and worsening fast.

At the close of treatment the therapist (SV) could conclude her as a happy, healthy and natural young woman with renewed appetite for life and love. In this connection I received permission to use her story for publication, as well as her own description of how she had experienced the treatment, also for this use. She gave me both (10). Her case sheet is the purpose of this chapter, while her own description of the treatment according to our diary will be described in the next chapter.

Medical chart

Female, 22 years old, suspected borderline/schizophrenic after physical maltreatment, incest and multiple rapes in early childhood. First quality of life (QOL) conversation: Student at a School of Education. Prior history of slipped disc, of stable type and not in need of an operation. Has been painless for some years, now again problems with the back. Skin eruption on neck and chest of nettle-rash type. Come because she is very sad with uncontrollable weeping episodes. Feels as if she weighs 3,000 tons and now it has to come out, she cannot hold it back any longer. Hard for her to show me confidence, but it gets better along the conversation. Would like to attend a process here and I offer to work at her feelings as well. I presume that the low back/slipped-disc problems, which are probably due to tightening in the back, can be solved. New appointment in one week. Objective examination: Very hesitating, very sceptic, very "sweet" and self-sacrificing. Holistic medicine is explained. At the end of the consultation she allows me to touch her back where it hurts. She does not allow me to touch her stomach during the physical examination. EXERCISE: Life story. Write the episodes you remember, where you had emotional problems. What happened, what did you feel, what did you possibly conclude? New appointment in one week. EXERCISE: Keep private all what we talked about here.

Second conversation: Tightening in the back for which physiotherapy does not help. Has written her life story, which we discuss. Topic: lack of care and outrage, violent by father, as well as dysfunctional family. Cries and is glad for the intimacy for which I also thank her that she is opening up. On the plank bed we work at the feelings in the shoulders, breast and stomach. She allows me to get deeply. Talk about the centres and our resources. EXERCISE: Find your problematic life topics - trust/distrust, infringement/escape. Sexuality: control. EXERCISE: Write incidents with emotional contents; circumstances that are relevant for the topics.

Third conversation: Process: "I am not important". Her pattern was that only her father was important, and she used a huge amount of energy to look where her father was. Since last she has had some new sensations as if something has healed. Had brought an action against a colleague about sexual harassment, which she won. It was brought up by the managers. We talk about sex, she is not dating her fiancé any more and has no desire. When with him she did not think of herself or her own needs. EXERCISE: Do not compromise with yourself on sexuality; do only consent if you really want to. EXERCISE: Write about all the sexual defeats and see how they are actually connected with "I am not important".

4th conversation: Has been in touch with the psychiatric system where she received a tranquillizer. She had a very violent weeping episode, could not stop crying and her fiancé was worried. She was lying on the kitchen floor and could not stop weeping. We talked about containing the feelings and get her fiancé to contain them as well. May call me on my mobile, if new troubles arise. May come weekly. EXERCISE: Works at containing the feelings. The feelings are OK. It is OK to feel sad, afraid etc. - and the feelings always stop again if only you get care, respect and give yourself the opportunity to sense.

5th conversation: Has had a hard time for six days. Stayed at home from school, but I ask her to go there again, be sensitive and strong in the feelings. If people want to judge her weak because she is sensitive, it is their problem. On the phone, she put her father in his place. Told him a few home truths and it has been really nice. Sex: She is doing a little better,

but not good at just being there and enjoying it - and expressing lust and pain through sounds. She is used to perform sex. Conversation about just being present and letting him enjoy you when he wants and in the way he wants - and expressing no and yes sincerely and continuously. **EXERCISE:** Express no and yes when having sex, generally say to and fro.

6th conversation: Arrive in a poor state, weeps and is sad. Tells me she is such a softie and has so little to give to others. However, she seems to be much more attentive, she fills up the space better now, so in my opinion she is making progress. She is doing fine with the no and yes exercise together with her fiancé, apart from yesterday where she felt she had to serve him as a reward for his being always so sweet to her. Had been feeling fine the first three days after she had been seeing me. Thursday had reported sick from school and is now at home again. This was very good because this way her fellow-students could see that she was physically ill with vomiting, so she has peace to heal her grief without having to account for them. We talk about that she is so perpetually self-extinguishing, devoted to duty and pleasing. She has to become an adult and make sure to know her own needs and get them fulfilled. On the plank bed we work at the time line in order to return to the original condition of being, pleasure and direction (zygote condition), and the patient manage to find this inner condition of tranquillity and balance. The patient has now got this as a resource point. The patient suffers from /residual urine/ with several earlier cases of /pyelitis/. Has achieved orgasm only once with her fiancé; she is simply not so confident "south of the navel". The uterus is "cold" and we work at it through the stomach.

7th conversation: Has chosen to postpone her imminent tiresome examination. She is very satisfied about this. We talk about that it is fine that she admit her desire. On the plank bed we work at the stomach and talk about what the stomach represents - existence, luck, desire and bliss. She still does not get so much advantage from sex. We talk about the G-point, and I ask her to explore herself and her sexuality. **Mission/Exercise:** We talk about love. I think of enneatype 9. Read "Maitri: The spiritual dimensions of the enneagram" (43).

8th conversation: Has been emotionally very unbalanced with many problems on the home front (father) and does not feel to be able to manage her studies. I understand her difficulties, which I find temporary. On the plank bed we work at legs and back; discs in connection with slipped disc are being manipulated in their place.

9th conversation: Is very well for the time being after her crisis. However, she was very sad yesterday. Her shoulder hurts and is being relaxed, whereupon she cries. There are troubles with fiancé, who wants to have children with her and to move together, but she does not want. It seems as if she wants something else with the relationship than him and the question is whether they are suited to each other. On the plank bed we work at the stomach, which is obstreperous along colon descendens. I give: **EXERCISE:** When going to the lavatory, let go instead of pressing. May come back again in 14 days.

10th conversation: It went fine at her birthday. Nobody argued and everything was nice and quiet. She cried a little, because she wanted so badly to get love from her mother and father, but she did not get it. She has become much better in putting her father in his place. Dreamed she scolded him so much that he bled. Now he had truly got what he deserved. Her much older fiancé would so much like to have children of his own, narrowly she did prevent it. - He had already thrown her pills away, and then ... We talk about his motives. She has got no desire for him, but on the other hand for her former fiancé. Nevertheless she stays with the new fiancé because she depends on him. In my opinion it is a mess, and I say: "You must carefully look at what your needs are, be kind to yourself and fulfil your needs - in a

completely selfish way. Stop thinking of him and his needs, think of your own". OLD EXERCISES: It did not work well. She is not good enough with herself. She does not deserve it. "You are simply not worth it", I say provokingly, and the tears squirt again. EXERCISE: Be good with yourself! If you want something - be sure to get it!

11th conversation: She arrives with a lot of power and determination today. We work on the plank bed at the stomach and breast regions. She contemplates to become a veterinary and we talk about this. Cries a little: I guess I cannot make it out. "Why not?" I ask. We also discuss her relationship and her fiancé writes: I admire you because ... I love you because..." and we go into the issues and it seems that the patient would like to be loved. I see trouble ahead. EXERCISE: Say what you need. EXERCISE: Write more on your story. Childhood.

12th conversation: Has attended my courses Philosophy of life that heals II and III[10]. Has spontaneously relived many episodes of sexual abuse by her father at the age of 2-4 years, possible because of the fine support of a large group of participants. Has found her life purpose[19,35]: "I bring life and happiness". She is doing very well and evolves exemplarily. Today we work at the stomach, which is tense. She has become massive and present, quiet and balanced. Her low back/slipped disc problem has on the whole disappeared now. A huge crack in the back today brought her vertebral column back in normal order.

13th conversation: Problems regarding her sexuality. The patient tells me it feels like a thousand knives around the vagina aperture. Gynaecologic examination: Nothing abnormal apart from 3 cm long scar corresponding to left labia minor at introitus [the vestibule]. At touching it, the patient goes into a dramatic gestalt with sexual abuse by her father - incest with full vaginal penetration - at the age of 4 years where she conceal herself in her hand. "I hide myself". The scar is compatible with the incest episode taking place and the reliving of the episode is very intense. The patient has no longer low back/slipped-disc inconveniences, especially no pain. No nettle rash apart from a few elements occasionally. The uncontrollable episodes have disappeared. She feels like a healthy, natural and standard weighing young woman and does no longer weigh 3,000 tons. Her big problems connected with trust are now solved. The incest trauma was apparently the cause. Can be concluded if her condition is steady now.

This is one of the most difficult situations you may face as a holistic physician: that the patient goes directly into process (come direct to expression) during the gynaecologic examination, when old scars in the sexual organs are physically touched. It is extremely important to have one's own ethics and sexual borders in place as a holistic physician, otherwise one can easily get into trouble in situations like these; it is even better to have a safe procedure for handling this situation, which we therefore developed (called acupressure through the vagina, see below). When we have a suspicion that a patient has been exposed to sexual abuse, we adopt a particularly careful and thorough procedure that give both the patient and the physician the safety required. The procedure involves training in backing out, visualizing of the whole procedure in anticipation and support by an experienced nurse during the process.

14th conversation: Come with slight, fresh bleeding from rectum, which has lasted for a while. Rectal exploration: This examination provokes contact with the gestalt where father had anal coitus with the patient as she was about 2-3 years old. The feelings are very violent and mental projections very powerful with projections that I am "nasty" and "like them". The assisting nurse at the clinic is called in and the contacted gestalt is dealt with together with her.

15th conversation: Home visitation in the evening together with the nurse after being called acutely, since the patient has experienced episodes of paranoid psychosis-like type where she did not dare to go out shopping because she was afraid - in mortal fear - to be assaulted and abused every time a man passed by. Did not at all dare to look at the shop assistant, who was a man, in the eyes or touch his hands. Was horror-struck to be sent to psychiatric department. Timeline therapy is adopted and I work at the scar in the mouth which derives from the patient having bitten herself during the infringements - there are distinct 1 cm big scars in each cheek corresponding to reiterated bites, and one very hard 5 mm big scar in the lower lip just at the left from the middle corresponding to a bite. Timeline therapy is processed with about 100 accomplished intercourses with father and two other men mentioned below. Patient says "I don't want to" "I can no more" "I don't want any more". About five accomplished intercourses with uncle as she was 2-5 years old, she tells. "He is so disgusting" "He is so cold". He says "So, here you are, now you shall have it" - this made the patient very furious as she did not want it - and "This is reckless" "I cannot feel it". And a little later - "Then he says: Now, nobody will want to have you". She is clearly awfully afraid they will leave her alone now. It was most traumatic when her uncle took her alternately in anus and vagina in a very quick assault where the patient could not at all manage to find her bearings, carried out with huge violence. She explains: "He takes me alternately in one hole and the other. I cannot stand on my feet after that. I'm afraid to get ill as one may only dry oneself one way. I cannot touch it. - It is as if, if I touch, it bursts. The whole is going to pieces." He took her three times in the bathroom and twice earlier in the shop. About five accomplished intercourses with grandfather in the basement, she tells: "He says: "This is a "lamb thigh". "It is not a lamb thigh." - and later the patient says: He says afterwards: "I will kill you if you tell anybody." The patient is emotionally affected, with massive shame and guilt. Strongly agitated for many hours. Afterwards very relieved. We are processing the whole time track hour by hour and about 100 incest infringements are exposed, with coitus at the age of 2-5 years with the three above-mentioned perpetrators (father, grandfather and uncle). It seems as if the three men have shared the patient sexually, with her father's knowledge and approval, but this is my interpretation based on details from the progress of events: The father comes with the patient to his elder brother, who is allowed to take her to the back of the shop alone where the infringements took place. The father comes with the patient to his own father who is allowed to take her to the basement alone, where further infringements are performed.

16th conversation: I work at the scar in the mouth, which arouse new memories of infringements.

17th conversation: Fit of paranoia again; I suspect that she gets bad in order to insist on care. Has to see a psychiatrist if paranoia continues.

18th conversation: "I have not felt like this before. I have always been uncertain. Have always let others control me. Now it is totally different and now only I myself am at the helm. And then, I am happy." Is evaluated to be through now. May come and see me again if required.

Both during the therapy and also afterwards contact has been maintained via the phone. She called several times during the following months to discuss thoughts and feelings, before she felt confident enough to definitively let go of the therapeutic connection. In a following paper the patient's own description through her diary will be presented.

Discussion

The most amazing observation from this experience is that healing, even the most terrible of traumas, does not take long time, if the patient enters the very special state of consciousness we call holistic healing. Years of the most terrible abuse can be healed only in hours of such intensive therapy. The problem is to get the patient into the process, because this takes a lot of trust, which the patient did not have, since sexual abuse exactly is the situation where a person in power (a parent, employer, adult) abuse the trust and cross the line called inter-human trust. Winning the patient's trust is really the art of holistic medicine and this will only happen if you love your patients, very much in the same way as you love you children (love is for some a very strong word, but we think it is the right word for the intense care that a good physician must give to his patients in order to be able to help them).

Another important lesson to learn seems to be the fact that many abused girls have the episodes of abuse completely repressed. The repression of trauma containing so much emotional charge can literally cause insanity. So when a young girl shows the signs of nervous breakdown or a borderline picture or symptoms, it is wise to take the possibility of early and repressed incest or other sexual abuse into consideration. A third important observation is that the process of healing needs an extreme amount of trust and resources. Only in a safe and loving environment can the patient heal. A fourth important thing to notice is that a psychotic episode in the middle of therapy can be taken as old emotional pains reappearing and thus a sign that the patient is healing. It is important that this natural and spontaneous process of regression is not blocked by anti-psychotic drugs, but that both physicians and the nurses of the team understand that this is a sound and natural reaction and yet another invitation to give intensive holding. Insanity in the form of acute psychoses in the course of holistic existential therapy is a sign of intensive healing.

If such infinite closeness and intimacy (or love as we call it) is possible, then the pre-condition for successful holding can be established in all the five dimensions: care, respect, awareness, acceptance and acknowledgement. The physical closeness is necessary for the healing, because without contact there can be no giving or receiving of physical and sexual acceptance, which is what the incest or sexual abuse victim needs more than anything.

The problems of ethics are obvious and severe. All the procedures involving contact with genitals must be carried out in standardized and safe ways (9,27,28,44). As the patient with very severe repressed sexual traumas are likely to project the content of the old gestalt in the same actual moment as the physician will touch the involved area, the patient will perceive the physician/therapist and his helpers as abusers in the present moment – often at the same time knowing that this is not true, but in fact only a projection, as in Anna's case. The therapist must not use a defending attitude at any time, but must be regretful and open to all the critique that is presented by the patient at that moment. Only by taking full responsibility the therapist can help the patient through the most painful of the traumas. Assuming responsibility as a holistic therapist for causing the patient to re-experience earlier incidents of rape or sexual abuse, even when projected into present time is called "controlled sexual abuse" in the advanced toolbox for holistic medicine (a advanced level 8 technique (9), which is a variation of the technique of acupressure though the vagina (44)). To use this high level technique takes a lot of experiences and courage. We strongly recommend intensive training in the 10 levels of holistic medical tools (9), before and supervision of the therapist during

such work. It is also very important to follow the laws and regulations of the country you work in. In some countries holistic gynaecological procedures as described above might be illegal to carry out in general medical practice.

Conclusion

The nervous breakdown of a young woman was caused by the spontaneous integration of repressed severe sexual abuse in her childhood. As the repressed material manifested itself she became more and more emotionally labile and extremely vulnerable. The tools of the advanced toolbox for holistic medicine were successfully taken into use. During the holistic existential therapy the patient accumulated resources to integrate the old trauma.

After the recovery of her human character and purpose of life in accordance with the life mission theory, the theory of human character and the holistic process theory of healing, she finally was able to confront and integrate her old emotional pains and heal the wounds of her existence.

The case story of Anna is an example of how even the most severely ill patient can recover fully with the support of holistic medical treatment, making her feel, understand and let go of her negative beliefs and life-denying decisions. Nervous breakdown in young patients might often be the healing crisis and not acute psychosis and the correct treatment in our opinion is therefore holistic therapy in order to integrate the traumas and painful emotions.

The sexologist or holistic physician should aware of hidden and repressed traumas, if the patient is emotionally labile for no good reason in present time. Early sexual traumas are often carrying the strongest emotional charge; making it especially important to look for such traumas in the therapy of the mentally unstable patient.

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Patient diary as a tool in the treatment

In spite of extreme childhood sexual and violent abuse this 22-year old young woman, Anna, healed during holistic existential therapy. Traditional, highly confrontational therapeutic tools were used to help this patient (like the Hippocratic sexological tools of acceptance through touch and acupressure through the vagina).

Her vulva and introitus were scared from repeated brutal rape, as was the interior of her mouth. During the therapy these scars were gently contacted and the negative emotional contents released. The healing was in accordance with the advanced holistic medical toolbox, using 1) love, 2) trust, 3) holding and 4) helping the patient process and integrate the old traumas.

The case story clearly revealed the philosophical adjustments that Anna made during treatment in response to the severe childhood abuse. These adjustments are demonstrated by her diary, where sentences contain both the feelings and thoughts of the painful present (the gestalt) at the time of the abuse, thus containing the essence of the traumas, making the repression of the painful emotions possible through the change in the patient's philosophical perspective.

Anna's case gives a unique insight in the process of traumatisation (pathogenesis) and the process of healing (salutogenesis). In the end of the healing Anna is reconnecting her existence to the outer world in a deep existential crisis facing her choice of life or death. She decided to live and in this process assumed existential responsibility, which made her able to step out of her mental disease.

The advanced holistic toolbox seems to help patients heal even from the worst childhood abuse. In spite of the depth of the existential crisis, holistic existential therapy seems to support existential responsibility well and thus safe for the patients.

Introduction

Many forms of therapy have been tried with rape and incest victims, but the therapy has often been less than effective and sometimes even counterproductive (1). The more severe the abuse, the more difficult it has been to re-establish a normal emotional range and a positive philosophy of life.

Victims have been treated with cognitive-behavioural and existential therapy, reality therapy, group therapy, and also with family therapy, analytical psychotherapy, supportive group therapy and couple therapy (2-15). With these methods it still seems to be extremely difficult to facilitate a process of existential, emotional, mental and sexual healing that takes the patient all the way back to a normal state of mind.

Quite surprisingly we have seen this process of full healing with holistic existential and sexological therapy helping a patient so severely abused both physically and sexually that such a recovery was highly unexpected and therefore worthy of publication, even though the patient diary is long.

Anna (16,17) was a 22-year old patient severely sexually abused most of her childhood by her father and two other men, who blackmailed her father to lend them have the girl for sexual exploitation with the threat to report him to the police, if he refused.

Her story is as terrible as they come and we have presented the case record, as well as her own patient diary below to illustrate what it actually takes to get well again after such abuse. The most amazing thing about the story is Anna's full recovery, now a successful university student with a boyfriend today, several years after the treatment ended. It is suspected though that she recurrently will have to face philosophical, spiritual, emotional and sexual problems in the years to come, because of the abuse.

We believe that her physical and mental problems have been solved. Only a strong and persistent relationship with her particular partner based on love, care, acceptance and respect will give her the holding she will need in these difficult periods. Her challenge now is to use her knowledge from the therapy to build a satisfactory life.

We render Anna's story in its full length, as it is important to show the huge, persistent cleaning work, which had to be done by the patient herself in order to recover, when adopting the medicine of consciousness. It is particularly interesting to notice how many negative decisions have to be found and released before a severely existentially and mentally ill patient does indeed recover.

The story also shows how the traumas available for integration in the therapy contained still bigger and more unbearable existential pains, as the patient gradually got more strength and more resources to go deeper into the "inner refuse bin", drawing still nearer to live her own purpose of life. This is a very important sign of the patient healing existentially. Her story starts just before she had her first break-through recalling the sexual abuse. The relation between the patient and her physician (SV), who together with the principal nurse and other nurses of the Research Clinic of Holistic Medicine in Copenhagen gave both individual therapy (18) and the holistic group therapy (19-21) she attended in the start of her diary.

This therapy is very much as the relationship between a caring father and a little daughter around four years old due to the fact that she had a long course of individual therapy (see the case report (17)) and the abuse started, when she was that age. Please be warned that some parts of the story are very gruesome indeed.

As sexual assaults and rape are among the life events with the most dramatic negative effect on quality of life the physician must take these traumas extremely serious. In most of the world sexual abuse of young woman is still very common and studies from different western countries indicate an incidence of about 15% of girls being assaulted sexually in childhood (2,22,23). These patients are also more likely to be physically abused later by husband and partners (22,24) and even the therapist who is supposed to heal and protect them. A reason for this is the sexual openness and the lack of normal sexual borders of these

patients, making them easy targets for abuse, in combination with a high degree of suppressed emotional pain making them highly projective.

These high numbers are disputed though. A problem with the sexually abused patient is that it is so difficult for the physician to be the one opening the old painful wounds of abuse, because he will inevitably be the projection screen for some the worst things that happened to the patient. As the patient cannot contain the overwhelming emotional pain of the earlier events it will be projected out on the surrounding world, and the therapist/physician will be the one most likely to get these projections.

Any impurity of this kind in the therapist himself will then be dramatically energized and brought into experiential focus and without the strict professional ethics in this situation it is practically impossible not to be "a part of the game". When this is happening, one reasonable theory for explaining the high occurrence of "professional incest" seems to be that many therapists themselves have a background as victims of abuse. The rationale for "professional incest" comes from an unconscious longing for healing of the therapist's own painful wounds on body and soul.

With a keen awareness of ethics and ethical behaviour, allowing intimacy and not sexuality between the therapist and the patient, with sufficient supervision, training and therapeutic processing by the therapist, this problem can be handled (1,25-28). In this case a therapist who was abused him- or herself might be the most wise and helpful of therapist, as abuse fully integrated turns into a huge gift of understanding and accepting life in all aspects, even the darkest and most difficult.

A therapist who does not know the evil side of mankind (29) is often not capable of helping patients treated as badly as Anna was. Only very few patients have an experience to the absurd degree of sexual violence that Anna had to recover from, and she did project very strongly, giving a good example of the above mentioned problem.

The principles of existential holistic therapy and the process of holistic healing has been presented elsewhere (18,19) as the use of it on mental and sexually abused patients (26,30) and all these strategies were used here. Most of the tools in the advanced holistic medical toolbox have been used to heal Anna (27) and the difficult (level 8) technique of acupressure through the vagina and anus was partly developed for use in this case (28). The core tools of the following process are found at the group level (level 5) (20,21).

The patient's diary is a very important tool in holistic existential therapy. It allows the patient to confront all the things that appeared in the therapy including the medical consultations. It also allows the patient to place the emotionally charged material in a safe place, until it can be processed in the therapy. It also gives an important record of the process, so that track is kept of the often very extensive process of healing hundreds of gestalts. Most importantly, it allows the patient and the physician to identify den negative sentences, the life-denying decision, from the gestalt, to help the patient integrate and let go of all negative beliefs and attitudes accumulated through the painful life events.

When reading the patient diary, it is important to understand that this text arises from a highly systematic and therapeutically well-supported exploration of the patient's subconscious material, with a strong focus on confronting the repressed negative feelings of the gestalt. The patient is encouraged to dive into these negative emotions and enhance them. As this is done, the old feelings of wanting to die, going insane or wanting to commit suicide appears in the patient's mind.

These states of consciousness are not born out of the present moment, but out of the painful past, and thus they cannot and should not be avoided in the therapy. They must be understood as difficult, but necessary phases of the therapy. In the beginning we had the fear that the severe existential crisis described in the diary could actually someday lead to the suicide of the patient, which would make this kind of intense therapy unsafe for the patients.

We have now closely observed hundreds of patients going through deep existential crisis, and quite remarkably, to our knowledge not a single one of these have ever tried to commit suicide, neither during nor after the therapy. This is in a way highly surprising, as psychiatric patients like Anna are known to often attempt suicide.

The reason for the intensive holistic therapy being safe, in spite of the dark content of the stream of consciousness, seems to be that what really makes a person insane is not the content of the consciousness in the present now - we can dream the most horrible things and still be sane - but our level of existential responsibility.

Choosing to confront the old traumas in existential holistic therapy in close contact with the therapist with the intent of healing, reflects this high degree of existential responsibility. So the patients can go really deep into their existential choices, and choose "to be or not to be", and still be completely sane, and therefore not at risk for committing suicide, because of the spontaneity of a psychosis.

There seems to be three fundamental themes of the existential crisis in the course of deep existential healing: 1) The loss of the old ego - the identity crises: Who am I? 2) Confronting the nature of the real self: what am I? and 3) Choosing life: Why am I here? What is my purpose and mission? The metaphor of the personal transformation, so well illustrated by Anna diary, is the transformation of the butterfly's larva: first it must lose its old self, to go into the transforming pupae; second it must remember its true nature and transform through this remembrance; and finally it must choose to be the butterfly, to get out of the pupae into the world.

Please notice that Anna became a student of holistic medicine, and her unique talents of understanding the process of healing and her own needs in the therapy was an important reason for using the traditional, but highly confrontative tools like "acceptance through touch", and "acupressure through the vagina" (26-28).

Diary of Anna

Monday of the group course

Yesterday evening Søren (SV) arrived when nearly all of us were sitting at the fireplace. I was very insecure. I was just thinking of how afraid of everything I was and how much I wanted to go home, as quickly as possible. Søren came over to me and was extremely considerate, most affectionate and nice to me. He hugged me a lot and said warm words.

Evening. Already this first day I feel it as a hundred days. Søren appears to be at his best today, and I have been glad to be here. Today we should get to know each other further, shake hands, hugs and a few words; and I noticed all the other participants. Actually, there are many lovely people here, and even those whom yesterday I thought would tire me, I do contain.

Afterwards we should choose a partner. A young man, Peter, came over to me and told he felt kindness towards me. At first he scared me; then Søren comes over to help me to sense,

and yes, I felt kindness towards Peter too. So we became partners. Later we made exercises where we showed each other attention in turn, care and respect. I think Peter and I were doing some fine exercises – and now I am very glad that he is my partner. He seems very affectionate and nice.

Later on that day my abdominal pains and shoulder pains worsened, and I got headache. Søren helped me and backed me in giving myself away to Peter and not being afraid to both give and receive physical care; thus we talked about trust.

Peter and I talked about wanting to break through, finding out what we needed, and making sure to get our needs fulfilled. I am quite convinced this is the way it will turn out. I so fervently wanted that, although I try to hold back, to be the nice girl, and therefore I hide the fear in my abdomen. I want, indeed!

Tuesday

I work at finding negative resolutions:

I trouble other people

I am troublesome

I am a burden

I am impossible

It's my fault

I am not good enough

Wednesday

It's in the afternoon and I am sitting at the fireplace together with Søren. I tell him that I am frustrated and scared as well as that I don't deserve to live and that I don't deserve life. Søren takes me on his knee and let me nestle close to him like a little child. I tell him that I have timed out. We talk a little about containing the feelings, and what strikes me isn't so much what Søren is telling, but it's the nearness, his holding me close and containing me, while I didn't thought I deserved to live; and there I was sitting on his knee and got slowly better.

Later the same day, in the evening, we are a few from the centre, who have gone to the beach. Last only Søren and I are left. I feel sad, as I have started remembering ever more difficult episodes from my childhood, all with the topics of abuse. A fire is lit, and I am lying on a rug, while Søren is sitting beside me. He asks me to go into my feelings. His presence and attention, which seem one hundred percent directed towards me, makes me calm, and I am not afraid to go into the feelings; I feel confident in his company. Furthermore, I feel such a trust in Søren, which I have never experienced in any person before, and therefore it is very important to me that we are alone as I am a very private person.

So I was lying there on the rug near the fire and I experienced how my body began to shake, almost in jerks, and how these jerks increased in intensity and how the intervals between them became shorter and shorter. Along the way Søren is meta-communicating and tells me that I shake, because of the energies, which my gestalts have bound and now are in the process of releasing.

I tell Søren in detail, which episodes are coming up from my sub-consciousness, and we have got many pauses en route, which I experience as most tactful by Søren. It should thereby be possible for me to come into something very profound and difficult. The sentence "this is unreal" comes up. Now I experienced, while telling Søren what I saw and sensed, that I spoke with a mechanic, strange voice, and I realized that the voice was not mine. Parallel to this, I experienced that I was standing at the end of the fire and was undergoing all those things, I

was telling about mechanically while laying down. In other words, standing I sensed the feelings and the pain connected with the abuses and infringements, and laying down my framed body talked about them.

This experience was real and very “physical”; I could distinctly feel that I was shifting between the two bodies. When life was hurting it got unreal to me and thereby I was able to hold on being alive again. Down on the beach I let go of the sentence “this is unreal”. It was like having received my first revelation.

Søren told me, after we have worked, that previously I was borderline which makes me terribly sad. It aches so much inside myself; and to think that I should be psychically ill! His stressing that I am ex-borderline now helps. He holds me close, gives me some of his warmth, and I can feel that he cares for me although I am a strange one, and it feels indescribably nice and at the same time almost incomprehensible to me.

Here are some episodes from the last few days I have come to think of. Spankings: My father often punished me by giving me a spanking on my naked behind. Once I was spanked, because I was eating too slowly (a dish with chops and tomatoes); as I was drawing with my green lettering pen outside the paper onto my blue velour track suit. Sometimes I got spanked if I did not eat quickly enough at supper and then again after having sat at the table for three hours. Actually, it was accidental whether I got spanked for not eating fast enough. I guess it depended on my father’s mood.

Communication: For days my father could be angry and not say a single word to us, and we knew that in any case we should not say a word to him either, nor should we do anything wrong at all. However, the problem here was that I never did know what was wrong, because there was never something for sure. If he needed to beat or yell, he just did so. Beaten and yelled at, I was never told why. Therefore, there was never anything for sure because there was never an explanation why he did as he did. I dreaded by father, and was mortally afraid of him and his violent changes of mood. After being beaten I was always sent to my room and was only allowed to come out, when he told so. There I would cry, silently, so he should not hear me.

Constipation: As a baby I ate the foam-rubber mattress in my cot, toilet paper in the bathroom and paper from the newspaper if accessible. Later on I very often got constipation and I remember that last I got it at the age of 7-8 years, when my mother had to “dig the shit out”.

Thursday

I have got a new life and a new face. I can easily sense how terrified I am. Talked with my partner Peter about it. We had become interdependent. I went into him because I am not able to be in myself; this is unreal. By going into Peter I get out of reality and so I am timed out. It was so tough for me when timing out as a little child.

I am empty

I am hollow

I want to go away

I want to live (14 days old: I fight for living, I am in trouble and through my will, I do survive)

Friday

Today I have had quite an experience. A real, beautiful and loving experience with Nete. All my kindness went to her and it was reciprocated tenfold by her. I was blissful. Never before have I experienced wanting to give love with so much devotion; it made my head

swim. I am eternally grateful to Søren for having arranged this totally unique and fantastic love background, which I feel we have got here at the course, where we are giving and receiving love freely and without any restraint, either in the form of words, physical care or in the mind.

It was during this totally fantastic and very beautiful experience that I got a full comprehension of many aspects of Søren's holistic medicine. I was deeply moved and am indescribably happy I had testified that love can be the door to a genuine meeting between two persons, who were so far away from each other to start with.

I can sense that love is constantly flowing here, and I myself have never believed that I should experience so much warmth and kindness by other people. I have started believing much more in love as a medicine, and I can feel this gets myself closer to the trustfulness, and actually this is a much greater gift to me. And how could it possibly be different? Søren is the first person that I have really trusted, i.e. pure trust, so of course he is also the one who opens me for that trust in other people as well. This is one of the greatest gifts I can get: to regain the trust in other people!

Sunday

At a time I choose to lie down as my stomach ached strongly, much more than usually, and Søren searched on my stomach for the place aching. He found the place, pressed at the spot, and then I felt the pain; a lot of pain. I cried violently and did really manifest myself. Søren asked me various things, while touching that place on my stomach, but I was not able to reply to his questions. The convulsions/jerks I had experienced on the beach together with Søren started again, and soon they turned worse than that night. I got cramps in my head and in my legs as well, and the cramps were more and more intense. Now Søren supported my head, and I began to feel a burning pain coming from the inside of my head. It ached so much that it felt like an imminent explosion. Søren told me that these were fever cramps from when I was a little baby and from which I almost died, my mother and father not being there for me. I liked that Søren was meta-communicating meanwhile. It reassured me in the situation.

The cramps grow even more intense, and soon I am beating myself, exactly like at the time my brother and I played when we were younger (a play where I pretended to be mentally handicapped). It grew ever more intense, I shake all altogether, and it was completely wild. I suffer unresistingly. Then the sentence "I want to live" turned up, the sentence being thus connected with this situation, this gestalt.

I almost screamed the sentence, and my voice reflected huge and intense pain. On having said the sentence, I got relieved. Soon bliss itself washed over me; never before had every single fibre been relaxed so much. Afterwards I released the sentence "I want to live", and again I shivered a little. Harsh.

Søren hugged me, and I can feel he is there for me; no matter what. I am so blissful! This is my second revelation. At the time I decided I wanted to live, I did very nearly die. I am surviving exclusively based on my will, and ever since have I been feeling as if I did nearly die. I have not been living, but did very nearly die. Release – bliss. One gestalt poorer.

Monday

In the evening I am manifesting myself again. I am in my room. Something big is underway. As many participants of the course are manifesting themselves, Søren has to leave me at regular intervals. This I am able to contain, and I am constantly feeling he is together with me in the mind; the mere idea of this preparing myself to pull through.

The manifestation initiates where I am in my mother's womb. I move a lot, but I have the impression that she does not want to feel me. So I move ever more. My body shivers; writhes and soon I fling body and head backwards and forwards. Søren back me all along and ask what is happening and what I am feeling. I feel his care for me, which makes me going direct into the pain.

I manage to get all the way around my mother's womb, I rotate, and soon I begin to feel a sort of rope round my arms and chest; I got wrapped up in the umbilical cord. I get the impression I should split; the umbilical cord feels like a straitjacket. I get water, amniotic fluid, in the throat, and I cannot swallow it. I get strangulation sensations. However, my mother still cannot feel me, she does not want to feel me, and I decide NEVER MIND. Soon afterwards my body become quiet and something else turns up.

I am back lying with my baby brother. My mother and her new partner have sex, and I say "She does not want to." Now I am on the track of the sexual assaults. After having said "She does not want to", I now hear and see the arousal and say: I DON'T WANT TO HEAR IT – OVER. Then comes: I DON'T HEAR IT. I start saying THIS IS BAD, repeat it many times and do not really want to proceed. I am strongly maintaining that THIS IS BAD, and Søren tries in different ways to proceed. He is very tactful and extremely delicate in the situation and handles my situation so gently. Now comes the sentence I DON'T WANT TO KNOW IT, then I DON'T WANT TO SAY IT, and this while I am crying and incredibly frightened. Søren back me up and let me know that he is taking good care of me. Then comes the sentence IT'S NOT MY FAULT, and here I can sense that I mean it is not my fault that I am arousing him (the perpetrator) and that the event is taking place. Then comes the sentence THIS ISN'T OK, and here I am uncovering it, I guess. Then comes the sentence THIS IS SECRET and the sentence YOU SHOULD JUST KNOW THAT YOU WILL BE PUNISHED, HARDER THAN EVER, IF YOU TELL IT.

Again Søren try to encourage me to proceed and to go deeper into the episode. I trust Søren one hundred percent, and I know he can help me and he wants to back me up through anything tough. Now I sense that the door is being opened, and I can hear the noise of somebody trying not to make a sound. It is my father coming in. He sits down on the edge of my bed, hold of my waist and place me, my back turned, onto his penis. He hives me up and down over him, has an orgasm, and lay me back in all the blood and sperm. While this take place and during most of the process, my body make twitching movements, in jolts, like during an intercourse.

Then comes the sentence IT'S NOT ME, and I say this because here I go outside myself and fly, I jump from an aeroplane and float in the sky, but I know I will hit the soil again. I am floating painlessly and land on the soil with a crash. Then come the sentences I DON'T WANT TO and then IT IS MY FAULT, and then YOU WILL GET PUNISHED, and I DON'T WANT TO HEAR IT.

While this happens I am back, 4 year old, talking with a very mechanical voice, almost in twitches, and the voice only disappear the following day in the afternoon.

Several things come to me as memories the next day: How my father had punished me, because I tempted him. How my hair was cut, how I was dressed and brought up like a boy to reduce this temptation. How I carried on with this, when I myself started buying clothes: men's clothes, businessman shoes and the like. I looked like a grown-up man in my clothes. How also my mother was feeling guilt; therefore she shut herself into the bedroom, unable to take care of me and love me, even when I tried to encourage her. How finally I had to leave

the bedroom, because I could feel she hated me. Maybe she punished me by her ill treatment; maybe it was her payback?

The food. How I was not allowed to eat what was supposed to be my father's filling for his packed lunch. Therefore, I ate roasted onions, macaroons and raisins for lunch after school. I was hungry, but there was not any food for me.

Tuesday

I still talk mechanically, am a little 4 years old girl who is very scared of other people, whom I believe will punish me, every single one of them. I feel as if I am in day care now, where everyone will be after me. Søren is incredibly nice and endlessly affectionate towards me. He is like, often before, my father, however it is completely different this time. Now I feel he is the only one, who really can protect me from all the evil people, and I prefer to stay near him. At breakfast he makes funny puppet dances with his fingers, which make me laugh a lot. I feel how I am only 4 years old and I am really not older. Søren's dancing like that with his fingers make me happy and warm inside; he meets me as the 4 years old girl I am, and he does it with consideration and affection.

Later down in the hall I do not dare at all to look at any of the other participants, and I am sitting safely besides Søren. He asks them, at my request, to take good care of me and let me be alone for a while. After a short while the twitches, the intercourse movements reappear. I am sitting beside Søren, I am totally confident because of his presence and I just go into the feeling. I suffer unresistingly. Now I do not care whether the hall is full, whether everybody is watching; because the hall is full and yet it is empty. Only trust and care are here. I do dare, and therefore I suffer unresistingly. The movements become more hefty and powerful. I can feel it is happening/I am getting raped many times indeed. Just as I am sitting there I get ever younger, and at the end I have got no language. Am I 3 years? 2 years?

The following sentences turn up: I CAN DO NOTHING, IT'S MY FAULT, I DON'T WANT TO, and I CAN'T STAY ANYWHERE. Together with Søren I return to the episode, where my dad had sex with me and afterwards he turns me round so he can spank my behind: everything is wet in the bed, and my whole body is aching, and I cannot be in the bed. I can stay nowhere and in the morning my mum clean up.

Thursday

Yesterday everyone from the male group found their purpose of life, and we had a wonderful evening together on the beach. We from the female group had arranged entertainment, including belly dance and songs, food including coffee, wine, chips and cake, and then we served them. Our mantra during this was: no control, no criticism and no claims. Well, I must admit that actually I enjoyed a lot just being allowed to do anything so they should feel comfortable. And they were much greater, when meeting us there at midnight; they were bloody men, indeed!

So this morning we should find the female's purpose of life. While meditating to music, the men went about whispering gifts to us women. At a point Søren come to me and whisper in my ear something basic about my purpose of life. I got so touched that I started weeping. It felt like so incredibly great words, and I can hardly believe that the words he told were about me.

Friday

I find my purpose of life: "I bring warmth and joy". I find this as the finest and most valuable gift I have ever got.

Tuesday

Sunday I came home after two fantastic weeks at the summer course. Yesterday I was 11 years old and wished for a fancy pink school bag. I am in flow, it feels so nice. Today I have turned 12 and have got the first period. It was a mixture of relief (I am like the others), sadness (because I should have it for the next 40 years) as well as a dislike about growing up. Ironically, as at the age of 12 I was already a little adult. I played a lot with my doll I had bought and took it for an evening walk. I felt I was back to the time, when I played with my big dolls house, something I was completely crazy about. Today I wish for a doll's house of my own. Again I think of the nice words Søren whispered in my ear about my purpose of life. It warms.

Wednesday

Today I am 13 years and wish for a dress.

Thursday

Good night 14 years and still without the dress. Sigh.

Saturday

I dream a lot for the time being, and Thursday night had a particular dream. I dreamed that I confronted my dad with the sexual assaults, that in the dream he got scared, and that the accusation was exact. He could not really answer back. Heavy artillery indeed I had been driving in position.

I was at a really nice concert, and at long last I had bought a super fancy dress, which I was wearing, and I felt simply so dishy! I felt smashing indeed, and it was really a fantastic sensation. Hurray!

Later I went dancing in the nightclub. It was divine and even a little better than usual. I did it to my heart's content, and it was fantastic!

Medical consultation at the clinic run by Søren (research clinic for holistic medicine and sexology)

Ever since the assaults I have regularly reverted to them by myself, on the hard bathroom floor, where I at the age of 7 years made quick and hard masturbating movements with three fingers, which took me back to the rape. I reverted because, although this was foolish, it was a form of contact between my father and me, the only contact we had besides when he hit/punished me.

I also did revert when having sex with my boyfriend. The brutality/fierceness was nearly always part of it, as I would prefer to be taken from behind quickly and hard, be pinched and bitten on my nipples.

Søren helped me to feel first the pain in my vagina aperture, my uterus, then my whole inner pelvis. He contacted the scars in my vulva and vagina; tactfully, balancing on a knife-edge. (The techniques of holistic pelvic examination, acceptance through touch and vaginal acupressure was partly invented to be able to heal the existential, mental, emotional and genital scars of this patient (26,27,28,31)). He brought me home to my uterus. He had been healing something inside me; this morning I saw my body as rounder, smoother and much more feminine. My psychosexual development is no longer like that of a four year old. I am on a fair way to become a woman. I got an enormous gift from him, and I am very grateful to him.

Søren dealt with healing the scar on my right labia, which was continuously chapping. It got better while he was healing it and en route the pain was very close to unbearable. At first came the physical pain, which was almost unbearable and then I enter into the emotional pain. There is a huge and intense gestalt, and my hands are completely clenched. I feel an enormous rage and can also feel that I am not able to release the rage although the sentence “NOW IT’S DAMMED ENOUGH” is swimming in my head like a mantra. Afterwards I get in dialogue with my inner little girl after having found the sentence “I HIDE”; thus I have been hiding in my own hand, when getting abused. It prevents an adult life, where I can react and be present in myself. I let go of this sentence, and now the rage changes. By the way I had a splitting talk with that little girl. As Søren asked me to release the sentence she tells me: YOU DON’T KNOW WHAT YOU ARE DOING and IT’S DANGEROUS. Then I tell her that we cannot play hiding the rest of our lives and be lying under a blanket without saying anything and without moving the rest of our lives. We must live instead, I tell her; thus I am able to release.

Afterwards the rage can get out, and at first I chat, then hit, then beat and hammer with clenched fists on two pillows, while I am saying: “Now it’s dammed enough!” That helps. It’s nice to let go of the rage, and that ease me a lot.

Sunday

New negative sentences:

I am ugly

I am afraid of men

I feel sorry for myself

She is too much

I am getting punished

Saturday

Now I realize that my dad did often assault me in the morning before my mum was awake.

Wednesday

The sentences:

I don’t need you

I need nobody

There is nothing to come after

turned up in connection with my getting stock of something, a gestalt, in which I suffer and which makes me very sad. I am talking with Søren, and more than anything else I need affection and care, I distinctly feel that, and still I do not need anyone/you. It was so obvious that what I needed most was somebody. Then appeared the sentences. And the reason why I do not need anyone/you is that there is nothing to come after. Nevertheless, I am not able to get anything.

Thursday

Over the breakfast I phone and talk with Søren about how I am doing. We talk about my sentences, and he says to me that he is there for me if I should need him. I just have to tell him I am need him. This is a good and extremely important thing for me to learn; it is a way of letting other people in. It is a way of approaching others. Presence. This opening is primarily due to Søren, as I feel I may “practise” on him. I can practise needing him and then learn to contain either his being there that very moment or having to wait for a better opportunity. It is safe to practise with Søren.

Tuesday

The sentence I AM IMPOSSIBLE turns up.

Wednesday

Two sentences appear:

IT'S ABSURD

WHEN I COME, I AM DYING

New memories came to the surface after that; about my aunt's treatment of me during the summer holidays at her place. I did everything wrong. I was always in the way. And about my father: I am seven years. The night is a hell. I do not sleep at all. I remember how I simply did not dare to sleep on my back, when I was younger. When my dad came into my room at night to have sex with me, I was always sleeping on my stomach. And when he had finished with me, "his screw doll", I would always return lying on my stomach, in the blood and sperm, and pull my arms completely under my body trying to give myself a little care. I almost see the whole episode like in a movie; how he sneaks up onto my room, gets hold of my waist, takes off my pyjamas trousers and briefs, and places me down over his stiff penis, my face turned off him. He moves me like it pleases him, all the while my small doll legs are kicking. He does not care whether I am completely dry, whether he gets crooked up inside me, whether I am suffering, whether skin may be trapped, whether I am bleeding, whether I get cuts and wounds. Sometimes he also laid me on his thighs taking me up and down over his penis.

Medical consultation at the clinic

I have been bleeding a little from the intestines for a while. Søren examines my rectum. I have the impression of getting filled up two hundred percent and it is tremendously uncomfortable for me. It feels as if a refrigerator is crammed into me, and I say I CANNOT STAND HAVING IT INSIDE ME. I do not feel there is any room. It turns ever more unpleasant, worse and worse. I would like to run away screaming. I cannot be there at all; it gets worse and worse. I CANNOT FIND MY BEARINGS AT ALL, I said, and now I am in the space with planets passing and stars hanging and shining. And I want to go home. I feel there is something completely wrong and that I am not myself. Now the disorientation takes over completely, and I am totally gone on. I do not know at all where I am. I would like to say to Søren, he shall be careful not to become like them (my dad and mum), but I cannot get myself to tell it. I say, "This is the worst thing you have done to me".

Afterwards I apologize for my projection. I cannot accept him in any way at all. I think "HE IS A PIG, HE DISGUSTS ME" and at the same time I am awfully ashamed of myself. The dislike is too heavy, the shame too overwhelming; I am not in me, I am not at home. I can feel I am beside myself, and this scares me terribly. I cannot find my bearings at all. Shame and pain. HE SCARES ME, HE IS LIKE THEM, I think. Søren says that the pain I am experiencing now is too intense for me to contain, and therefore I am projecting it onto him. I know he is right. I know I am projecting big time onto him. I am not able to have it inside me; I feel I cannot contain it, not at all. The following sentences come: I am hiding, I am in the space, he is disgusting, I am cooped up, I don't care, he doesn't care, there isn't any room for it.

I feel bony and thin, skeleton-like. Søren asks whether I was thin as a child. At first bun fat, then thin, I answer. At our place there was actually no food. I often ate roasted onions or

half a bag of macaroons, when coming home from school. Usually there was not any real food for me. The fillings available were for my dad's packed lunch; the rye bread too, so I was not allowed to take from it, or one slice at the most so nobody could see that I have taken some. Søren says lack of care, and while he is saying the word I chant in my head: I DON'T CARE.

I stay at home from work. We get hold of Marianne (the nurse) and asked her to assist in conveying me holding. She would like to. I am just sitting in Marianne's arms while we are listening to some nice music. I almost fall asleep there in her arms. As Søren arrive we deal with my time line. Marianne wrote down everything that did happen.

The notes by the nurse about Anna

Anna is back in time, about 2-3 years old. They should remove her nappy. She could not really speak yet. Both her mother and father did harass her; the mother abused her violently, her father sexually. The father was the one doing it at night, while the others were sleeping or in the morning when her mother was still sleeping. He did not care if there was blood on the sheet. Anna experience that all this fills her up, it fills her whole stomach. The mother used a spoon in order to make her bleed, so her father should not abuse her. Anna experienced that the mother did it to be nice to her and to protect her from the father. She has got the feeling that her sister has been abused as well.

The contents of the gestalts: She (the mother) hates me. He (the father) hates me. My sister hates me. The mother did not want to give Anna prunes, as asked for by the father, when Anna was constipated. They called her a particular pet name, when carrying out the ill treatments. When calling her Anna they could not do that. It was as if the mother and the father knew what the other was doing. Anna also thought there were other people who knew something about what was going on. Many different people had baby-sat her. They should have seen there was something wrong, when changing her. The father stopped, when she was about to enter school, but the mother carried on and Anna remembered how the mother laid her on the changing table as she was 7-8 years old. At that moment Anna wished to die. Was sent outside, did smash a rough plate hoping she could cut her wrists. She also tried to run away and hide. The sentence I HIDE. The little hand is completely squeezed and unapproachable. Extremely slowly Anna opens her hand again.

Monday

I talked by phone with Søren about revenge and rage. I am totally, terribly angry. I feel as if my rage stretches thousands of kilometres; really far! First I do not really want revenge, but then the vindictiveness comes to me. I say a lot of angry and confronting things to my father at that moment, and as soon as I have said them, my back is feeling better.

Thursday

I read in the newspaper today that a 53 years old father, who received 2 or 3 years of imprisonment and paid twice DKK 35,000 damages to his two daughters, that he had abused over a four year period. The girls were 7 and 12 years old. [The legal issue was discussed many times with the patient during the therapy; the focus of discussion was the best interest of the patient. We agreed that she was not strong enough to confront her offenders in the court. After the therapy she could go to court, if she wanted to From a holistic medical

perspective the patient's interest is above the general interest of society; justice is less important than the health and well being of the patient].

Sunday

Medical consultation at the clinic with Søren and Marianne, the nurse

As Søren and Marianne arrived I was in the paranoid psychotic condition. [It is important to notice that this psychotic episode seemed to be a natural part of her healing and she was not drugged during the days of mental crisis]. The first time I noticed that I was paranoid was on Friday. I was walking in town shopping and I got scared on the road. It is difficult for me to find the words for it, but I was aware that I was getting hot flushes, becoming dizzy, nausea and a huge desire to run home. In fact, this happened again the following three days when out for a walk. I get afraid when people walked in groups. I was especially scared of men on the road; I thought they wanted to snatch me and take me along. I thought they were able to jump inside me, like invading me and taking what is mine and in a way occupying me. I thought there was nothing I could do and they could do whatever they wanted, for instance violate me, beat me and rape me. They might pour boiling water and ice water into my vagina, stuff tins up inside me and tie me.

The rest of Saturday I did not go out. Again panic after having been outside for a short while; I could barely take the receipt from the man, who brought me a pizza. This was too close to him. I feared he should catch my whole arm and just drag me along. Again things are running about, I got hot flushes and feel terribly unwell. I feel almost as if I am chocking. That sensation I got earlier today as well, when a friend, Peter, called. We were eating so I told him I would call him back, but as I had put the receiver down everything in me shivered and trembled, and I told my friend they now could also come in through the telephone. I felt invasion, thought there was no refuge for me; that they could come and hurt me also through the telephone, as if Peter could actually come out through the telephone and be physically in my room.

As Søren and Marianne came, Søren made it clear to me that if I was not willing to put the lid on my "inner waste bin", if not now then after having processed, he would have to get in touch with a psychiatrist, a good friend of his. This made me completely terrified, and I got terribly afraid he was going to do that and that they will fill me with drugs. Through our conversation I realized that Søren could not have me walking about being psychotic, because I am his responsibility. Furthermore, I saw how I have neglected my own responsibility in this situation. I have continuously carried on opening forever more stuff although I had not managed to come to terms with and integrate well what I had just been processing. I behaved like a too eager little girl who, because I got unlimited love when working with tough things, just unrestrainedly kept on opening new and more hideous things. I realized that it was connected like this, and then we proceeded.

Next Søren dealt with healing the scars inside my mouth [the standard procedure described in (32)], similar to healing genital scars described above]. First he touched on the left side of my mouth. I cannot feel anything at first; some time passes by, and then I begin to cry. I tell how much I have been thinking of my paternal uncle the last few days. I have always had an image of him as most arrogant, evil, indifferent and indescribably cold; terribly cold. I feel an indignation/rage towards him, while I am lying here; he did always feel above

all of us, and in fact he is just so small, such a small shit. While Søren is dealing with the scars, more and more images come to me. They concern my paternal uncle, who had raped me totally five times. I shall give a more detailed description of them tomorrow. The episodes in question are particularly connected with the scar I have got in my lower mouth, which is so striking that its surface almost feels like a tooth. As we are dealing with it, I feel like going to scream, and we try this in the duvet. It's as if I don't know at all what screaming is about. How do you scream, I ask Søren and Marianne. It's difficult for me to catch the feeling behind the screaming. It becomes a very half-hearted attempt. I would very much like to try again, at another moment.

Notice that this work with the patient's scar tissue is probably the most direct application of the formula: "Feel, understand, let go" (19,25,31-33). The gestalts are picked up directly from the tissue and processed on the spot. This implies the patient's full collaboration and easier, when one or several persons are present to give holding. Interestingly, the scars do often disappear subsequently.

As Søren dealt with the right side of my mouth, I get a lot of images from my paternal grandfather. When I, at the age of 2-4 years, visited my paternal grandparents along with my family on Sundays, he always had to finger my "lamb thigh", meaning that with his enormous fist he took hold of my right thigh and grasped very hard. Then he moved his hand higher and higher up to my lap. Everyone saw and heard it on Sundays.

From time to time I visited them. Every day they were taking a nap after dinner, and sometimes when my paternal grandmother slept, or pretended to be asleep, my paternal grandfather took me on his arm, as I myself went too slowly and took me to the basement. Down there he dragged and raped me. I feel that he just stood, then grasped my waist, my face turned to him, taking me up and down over him. It didn't take so long, and then he dragged me upstairs again, to my paternal grandmother who was waking. Then she would have me go with her to her work, to take me along in a very noisy machine hall without putting the ear protector on, telling there weren't any left and that I just should stop my ears. It was indescribably loud inside that hall, very loud indeed. At other times my paternal grandfather took me along outside and raped me out there. The basement episodes I do see most distinctly, and I remember the fear to go to the basement or just approaching it.

Wednesday

Session at the gestalt therapist [Anna received support from both our medical team and a gestalt therapist connected to the clinic during this period]

I established contact with my strength. I must pay attention to my needs: I have to allow both to receive and to make demands towards Søren and towards my friends. In the future we shall establish contact between my inner child and my outer woman. Plan: I am in a psychological crisis, and the following three weeks shall pass by having a nice cosy time with relaxation, the colouring book, women's magazines, TV-serials, good food as well as sleep and rest.

Sunday

I can feel/sense that my dad was not allowed to have me for himself. He was the first, who committed an offence against me, but although I was his daughter, he did not own me. That is, my father could not have me for himself, this my paternal grandfather and my paternal uncle would not allow. My father should share me with them, otherwise they would punish him, hurt him badly. So, in order for my dad himself to be able to carry on his assaults he had to share me. I do not know which punishment they would adopt on him; maybe they

would report him? That is unclear to me. My dad was very much and sincerely sorry about having to share me with them. He could hardly make himself to do it, anyhow not to begin with. I guess my dad was perfectly aware they would not be treating me like he did; I guess he knew they would be violent and brutal towards me. Nevertheless, my dad did that. Here come the episodes with my paternal uncle, which turned up while Søren was massaging the scars in the corners of my mouth:

The first time my dad took me along to my paternal uncle's shop, he let him take me to a coal black room, while he himself was passing the time chatting with the shop assistant, while his big brother was raping me, I believe I was about 4 years old.

The second time my uncle raped me was not in the same room, but in the shop itself. He placed my hands on a long wooden top, and then he had sex with me, apparently in my rectum. I am getting the sensation of being held round the throat, the chin and the mouth. It is as if I am actually screaming all I can; I am kicking, flapping my little legs. I am struggling, however his hand is so large that it covers throat, chin, and mouth as well and absolutely no sounds escape from me. My scream does never get out, but drowns in my throat. My legs are not allowed to run across the floor, escape from him; they are just hanging in the air, kicking.

The third time my uncle raped me is no doubt the worst and most sadistic one. He is lying in his bedroom and is waiting for me to go to the bathroom. I am at their place playing with my two cousins. He just snatches me, so I am kicking and he holds his hand before my throat, chin and mouth and says to me: "I bet you will get it!" and then he places my hands on the bathroom tub, uses his other hand to grasp my waist, after which he has brutally sex with me, in the vagina and the rectum by turns. He shifts so quickly between the two that I get very muddled. I feel completely confused. The following sentences turn up: He is cold, he is disgusting, he doesn't care, he is so violent. After he has raped me, I cannot at all touch myself at the bottom. I cannot at all wash the blood and sperm away, because if I touch it, my vagina, my rectum and everything "at the bottom" will go to pieces or explode. The pain is unbearable and makes me completely dumb and paralysed. Before my uncle leaves me, he says: "If you tell it to anybody, nobody will want to have you." The fourth time he raped me is also in their bathroom. Here he is sitting on the edge of the bath, and again he holds one hand before throat, chin and mouth, while his other hand is round my waist. I am turned away from him. He is penetrating my rectum. The fifth time, again in the bathroom, like the fourth time, except that now he is sitting on the toilet instead of the edge of the bath.

The night between Friday and Saturday I experienced getting serial raped while sleeping. I wake up at the first rape, at 3:00 hours in the night. Then follow three subsequent rapes, totally four times. The sentence "I have got nobody" turns up. It is connected with my father lending me to my paternal grandfather and paternal uncle, and as my mum was like she was, I had got nobody to watch me. After these four times I feel like going to stop with the consultations with Søren, 100 percent. The note from the night I wrote en route reads: In a moment he is going to hurt me, very much indeed. A little later I get raped for the fifth time. I am so unhappy and have now got so terrible pains in the stomach and the abdomen that more than ever I am about to take a tranquillizer. Then come two more rapes; they are connected. The sentences: It's really bad, I want to die, I want to go away, and I cannot have this, turn up. And it is really bad. I call Søren, but he does not answer the phone. A little later follows a serial rape of five, so at last I got at total of 12 times. My last note from the night reads: "Unbearable pain".

A moment later something particular happens. The above sentences are striving in my head, so I do as follows: I clench both hands so hard that it actually feels as if I am locking them. I think: Now they cannot open again, and now it will stop. The sensation this time of being hidden is totally new. It is not like I have experienced it earlier. This time it is like towering walls of black armour plating are rising round me, and I think that absolutely nothing and nobody will be able to penetrate. Nobody. These high, black armour plates thus surround me and actually I am calming down remarkably quickly now, because nothing and nobody, indeed, can trespass on me. When waking up in the morning I am very unwell and I feel very sad. Furthermore I am angry with Søren, because he did not at all phone me on Friday, and I find he was mean. When getting hold of him, he says I shall get in touch with my gestalt therapist and talk with her, as she is my therapist now. I feel a confusion inside myself and think that maybe Søren is withdrawing from our therapy relationship. During the night I got a nightmare: Søren and I are going for a ride in the car. He starts scolding me, because of my irresponsibility and he is terribly angry with me. I wake up from the dream, just as he places his hands round my throat and is about to strangle me. I remember now: My mother asked once my father to kill me. I am asking our in the air: "Why didn't they just kill me? Why didn't they kill me?"

Then the next morning I talk with my gestalt therapist on the phone and we discuss my relationship with Søren; I have to find out what it is about, and if I can phone him and when.

Tuesday

Last night I dreamt that Søren gave a tough message for me: "Spread your legs and get it over with!", implicitly that the way ahead of me was the way through the pain from the numerous assaults. No time for pity!

So Sunday night my attitude was quite a bit different. I told myself that I could easily make it, that I was strong and that I shall be doing all right. Then I am on my stomach and let the thoughts come to me without struggling.

Assault: Just before I fall asleep, my father comes in my room. He penetrates me, my vagina, and it is quickly and non-violently. He is doing it almost gently and appears sad.

Assault: It is in the morning: my father is in the bathroom and I have to pee. My mother says: "Just go in there" and I do it. My father takes me to the shower cabinet and has sex with me. Again non-violently.

Abuse: My mother has taken me to the bathroom. Again I am not able to get rid of the stools; in any case not at the pace and at the moments my mother wants. She places me my hands and legs on the floor, and my behind up, like when she had to wipe me. She uses a spoon, and to start with it doesn't go so far up because I tighten and work hard against this. Then she puts me with my stomach on her knees and starts. She says: "You bet I'll get it out". She keeps on digging, and this time she gets much deeper. However, there are no stools, and she keeps on saying she will get them out for sure. She is so eager to get something out and tries with the spoon to get in my rectum as deeply as possible. It is as if she has broke down, as if she is completely lost in the situation.

Assault: My paternal uncle. I guess it is in the bathroom while he is sitting on the bath. He penetrates my rectum; it's most brutal, and I feel a huge pain. I feel it is something corresponding to a very hard pipe, which drives up and down in my rectum. It hurts far up, to the very end in front of the navel.

After all this I feel rather exhausted. Most of all I felt like being held close. Incidentally, I must add that I feel very comfortable with colouring in my recently purchased colouring

book. I colour with crayons and I am perfectly aware this is as creative as I can possibly be, now that I am not more than four year old; so that is the way it should be.

Yesterday night

I am on the point of sleeping, and my mother is in my thoughts. Again I go into the episode from the previous night, the one where she told me she wanted to get it out for sure. Her whole energy in that situation is coal black and evil. Now I see her more as a sadist, so she appears; she didn't cease while digging about in me; she just carried on, got ever deeper in my rectum as if she should get that out, no matter what – and she went on and on. She herself decided when to stop, and that didn't depend on what and how much stools she got out of me; it was completely independent of this. Apparently, she didn't even do it in order to get the stools out of me, because there weren't any in that episode. She did it for the simple reason of doing it! A sadist, I guess, is an appropriate word indeed...

I also think of my nightmare from Friday night where she asked my father to cut me away and off his life. What is that woman's agenda? It seems as if, only to a certain extent and maybe not at all, she is the victim in the home. The story has always been that she was the poor one, the one who was being oppressed. It rather seemed as if this story doesn't really hold. I get the impression that my mother actually was ruling at home.

Poor me! I do know what I find most difficult and disgusting. I lay down on my back, in my bed. It's terribly unpleasant, and also it doesn't take long before I start crying, then sobbing. I'm sad. It's tough!

Assault: my paternal uncle. Now comes the sensation of a piston up inside me. With the sensation follows the piston sound. I can hear it: "dunk, dunk, dunk" in rythm. With my fingers on my stomach I feel exactly how far up the pain goes. It reaches up to the left of the navel; and then I am gone. It's as if I am hearing the whirr of wings. I have got the impression, and more than that, that I am actually flying high up in the air. I am a bird, and I hear the wind blowing while I am flying about up in the air.

Again I lay down on my back, now with my fingers and legs spread. I think; I cannot do that, and then I do it nevertheless.

Assault: my paternal uncle. Again he knocks up inside me, brutally, and I feel again that the pain goes as far as up to the left of the navel. He simply hammers up in me, and the sound follows: "dunk, dunk, dunk".

Assault: comes in series. Exactly the same situation, exactly the same contents. Just like that, again. It can only be my paternal uncle the second and third times!

Assault: my paternal uncle. I sense he presses and presses his too huge penis into my rectum. He presses and works hard, and slowly it gets deeper and deeper. It gets as high as to the left of my navel, and then I can sense that he has got an orgasm; he empties himself up there inside me. A second later I get an uncomfortable nausea. I get dizzy. His sperm is up inside me, and it feels as if it's completely up in my throat; as if, if I vomited now, I would be able to vomit the sperm.

Rape: paternal uncle. The piston sensation, the sound: "dunk, dunk, dunk" and again pain till left side of the navel.

Rape: They press forward up in me like worms, it's difficult indeed, but they just carry on like dry worms without any slime just waiting for the friction resistance to disappear. They slave away, persistently. Nausea again.

Now I lay down, my legs spread and my arms above the head, the fingers free. Terrible. Rape: paternal grandfather. This time I am completely paralysed with fear, totally paralysed,

and I do not make a single movement. The pain goes to the left of the navel. I get the impression I am going to be killed if I do anything wrong, and I sense my paternal grandfather's energy. Now I am gone. Now the wind is howling and I am out in a storm; there is snow everywhere. Am I on the Antarctic? I guess so. I have to stop here, the sentences "I get smashed up" and "I go to pieces" appear.

Again I lay down on my stomach, and I can feel a huge pain. I am aching unbelievably, corresponding to the rectum and up to the left of the navel. Now I embrace myself, hold myself close, like I did just before all this happened tonight. I hold myself; it feels so nice and safe. It's okay. In the evening, in the bath: I feel a warmth inside, it's lust, I know. I don't feel like touching myself at the bottom, so I massage and caress my breasts. I do it in a completely new way, and it's really nice. It makes me glad.

Tuesday night

Rape: father. I am supposed to sleep in the evening. He reaches halfway up towards the navel; it hurts, but he doesn't do it so violently. He says to me: "I will ..." and doesn't complete the sentence. I guess he wanted to say: "be careful/do it carefully" or something like that.

Rape: father. He presses himself up in me. When up there, he makes stubborn pushes with intervals. He gets to the very bottom, but it isn't violent. He takes me obliquely off the navel. I think "It isn't so bad" and sense there might be some lust for my part.

Rape: paternal uncle. He slaves away, again with his huge hard pipe. I have got the impression it isn't himself, rather an object; maybe a candle, it feels very thick. He reaches higher than the navel this time. Then it's as if there is a shift, and now it's he himself who is penetrating me. He enjoys this, and it's the first time I hear him moaning. It takes much longer than usually and it isn't violently now compared to earlier and with less hammering and beating. Now I get the sensation that my labias are forced apart, and that something is penetrating me. My vagina feels now huge and extended, like a hand; a whole hand is inside me. Then appears the sentence: "I don't want any more".

Then I consider how I will get my productive and hard working subconsciousness shut down ...

As a solution I place myself in the doorway of an imaginary shop and say to the numerous "assaults" appearing and impatiently standing in front of the shop wanting to enter: "Sorry, the shop is closing now. I am sorry that I have to disappoint some of you. – You may come again tomorrow. Good night and sleep well everyone". I didn't want to make any of them cross, but wanted to admit that they are here and show them that it's quite okay with me, however, that I am the one having the last word with respect to the shop's opening hours! It was totally super cool that actually it did succeed! The shop closed indeed! It felt really good to wake up in the morning, on Wednesday; I got the sensation of controlling the situation. It was indescribably good!

Wednesday morning Søren came, because I had asked him to come and hold me close. So he did, and it was really nice. Wednesday evening in the bath: Again I feel the warmth and lust after having watched myself naked in the mirror. I observe my behind and the region round the arsehole. I find it has become prettier and can look at it and feel that I am more present in that region, especially round the arsehole. Its former flat appearance, the death, seems decreased. My breasts too have become prettier than they were earlier. Tonight I feel like touching myself at the bottom, and I am feeling myself, touching where it feels nice, and am thinking then: "It's not so bad"; consequently, there must have been a lust aspect with my

father! It feels good what I am doing. Again I massage my breasts and think they are wonderful. Yes indeed! It's really nice to caress them and feel them as whole breasts. While I am doing this, something happens, which I regard as curious. I touch my breasts and at the same time I dream wearing my fine, blue summer dress; it makes me feel so super feminine. Curious! But it's great, and today I feel that my breasts are perfect and that I am gorgeous. I go to bed. Suddenly the sentence "Nobody likes me" turns up.

Wednesday night

The sentences "I hate her, she is nasty, she is disgusting, I loathe her" turns up. Afterwards I stand on the shop's doorway. I tell everyone that I am very tired, angry and not at all in the mood for more. I say that I don't care whether they get cross, as I am the boss, and that I am really very tired and am going to close the shop. Full stop! They do not even protest, on the contrary it's as if they are mumbling they understand all right and wish me sweet dreams. Too wild! But I was simply done in; I was a totally flat battery yesterday as I went to bed at last.

Thursday

The following sentences appear:

It's odd

It's really curious

(I'm not good, am I?)

(I'm worthless, am I not?)

Friday

Yesterday afternoon I released myself "I hate her"; it was so extremely violent that I doubted whether I would stop crying again. I sensed how the earth disappeared under my feet, and I almost put myself across the table in order to hold on, have the connection. It was almost a revelation, I felt. "I loathe her, she is nasty, she is disgusting" – these sentences gave me such a heavy nausea that I hurried up to the kitchen to release above the sink. I was very close to vomiting. Two new sentences turned up: "I'm good for nothing" and "I'm a failure". As "I'm a failure" appeared, it was so terribly violent that it send me direct into space, without any earth connection, floating about between the planets. This made me dizzy. "I am out in the space". While at home and in bed, I think again of "I hate her" and "I am a failure". The sensation of being a failure, as well as my own self-hatred are the things that right now are worse than the rape. I write: "I cannot be in myself" and "I want to leave". Then follow:

Rape: my paternal uncle. The bathroom; he sits on the toilet. It goes so extremely fast, so quick up and down, in the vagina, I sense. So fast, so if I said a sound it would go like me sitting in a shopping trolley, driving across an uneven surface. The pain reaches the navel. Having my back to him, it's unclear to me whether he is holding his hand over my throat, chin and mouth, I guess so, and actually it doesn't bother me. I feel unbelievably like making fun of him, I really would like, while he is slaving away in me, puffing and blowing, to say that sound like when me sitting in a shopping trolley ... I just think he is so ridiculous, and that it would be great fun to say that sound, as his wanting to hurt me so much would be such a marked contrast to my just making that sound, which is so funny indeed. That would thwart his sadistic agenda! When finished he said to me: "You are worthless"; and now I can feel that I understand no more. I did acknowledge it: "I am worthless".

4:35 - still awake, the garbage workers arrive outside

5:01 – still awake

5:30 – still awake

Friday

Today something is different. I have got appetite again and have eaten quite a lot today, about 6-7 times! That's really good! Talked briefly on the phone with Søren tonight; he said that he is with me all the time, and I find I can feel that. He said to me that I have broken through! My eyes filled with tears, while he told me that, and it's also what I am feeling inside myself, I guess. Oh, this is fortunate! He said that I was not any longer in my dark side. Imagine I should break through! I am feeling really fine too! Actually, really fine indeed.

Saturday

It was a wonderful evening yesterday; I just enjoyed staying at home together with myself. I watched the movie: "It's me talking" from I don't know when, and it made me laugh a lot. Old and entertaining it was great. I slept very well tonight and had two dreams.

1st dream: Where I was sexually together with a gorgeous girl; wonderful breasts, warm lap, and it was fantastic. I gave her quite a lot of compliments and enjoyed her a lot. At the end, in the dream, her labias broke; she was bleeding and showed me them. They were bloody, torn, and she looked badly knocked about. Then she said I should better be checked up for venereal diseases... (I found her gorgeous). 2nd dream: About me rescuing my sister from an evil man battering her.

Søren told me later, as I told him about the dream, that I was the one raping my sister. I can see that all right and told him about the time, where Marie (my sister) fell in love with me and I subsequently fantasized about wanting to throw her down on the bed and doing with her whatever I pleased. He said that it was good I did not get hold of her. I must agree. He also said that most likely I would not do that today.

Saturday

A friend of mine talked to me about the relationship between Søren and me. That it is a unique doctor/patient relationship and I explained how he has been able to support me in very difficult times and open up for things that I had hidden, even from myself. She said she had been waiting for me to tell her about it. She said I could trust her. The amazing thing was that she did not condemn me at all; on the contrary she listened so carefully, respected me and acknowledged me fully. It was amazing how pure her intentions were. She respected me, acknowledged me and let me know that she wished me all the best, respectfully offering me that if I wanted I could discuss whatever I wanted with her. However, I feel I am doing fine now. As I said, it was an amazing conversation! At one point she began to cry; I told her that indeed I have a deeply based problem with trust and that in the future I will do my best towards a trusting friendship. Further she said that she knew I would succeed in this and she was looking forward to it, and meanwhile she was there for me. At a point, as we were discussing trust/lack of trust, I said: "I suppose you have guessed that I have been sexually abused", having hinted it earlier. She nodded affirmatively. She felt having to protect me/spare me any evil, including Søren, as she asked: "Could he think of anything sexual?" She mistrusted him, but I answered no.

Later, during the night, I begin processing. I am in a completely white room; there are no walls, no floor or ceiling. It is white and infinite. While I am there, two sentences appear: "Nobody is there for me" and "I am miserable". That is a true sentence, "Nobody is there for me", it fits fine on me, and I felt it so clearly that it made the sentence "I am miserable" appear. I release them during the night by means of the roll. "I am miserable" turns up again. At a quick pace follow: "I can do nothing, I know nothing, I am not good for nothing, I am always so foolish, I want to die".

Søren called me by phone, before I went to bed to ask, whether I was okay, and I answered that I will make it. However, while in bed with the wish to die and wishing for it so intensely, I became afraid of staying alone and called my ex-boyfriend, who came to hold me close the whole night. He stayed the following day until the afternoon, where I had an appointment with my gestalt therapist.

Sunday night

This is the night, where my boyfriend held me close.

Sunday

My mother and I are in our bathroom. She has been digging for a very long time, and suddenly she says: "Now it's enough!" She placed both her thumbs on my throat, in that small cavity and now really she wanted to kill me. She squeezed and the sentence "She is going to kill me" turned up. She carried on until I am lying unconscious on the bathroom floor. Maybe she thought I am dead now, or even a practical aspect turned up, where shall they put the body? How shall she make it seem an accident, when having been strangling me? I know, that I am not in the present time, and therefore I stay and wait.

Thursday noon

I took a bath, and it was a really unpleasant experience. I experienced I was sitting in our own bath together with my father; I was about six years old, and my father had sex with me. This time it was completely different. I was facing my father, looking at his chest and the relationship between us had changed. My sensation was that my father in a way accepted his lust for me and that he preferred having sex with me, rather than with my mother. I was his mistress; there was some equality, some acceptance. My father enjoyed me more than ever, and in a way I liked it too. In the bath at my friend's place, now I am suddenly heavily pregnant and am going to give birth. I think and say out loud: "I cannot give birth to my child like that. – It will be a trauma for the baby." This comes up, while I am sitting in the position for a pelvic exam. I cannot manage to do it at all. I can now see the situation with my father in the car again: he hardly can have himself do it, to kill me, but my mother has ordered it. First he drives like a fool to subsequently stop the car in order to strangle me. The sentence "He is going to kill me" turns up. As I release it, also the physical aspect comes in. I cannot breathe, my trachea is choking, and I struggle for breath. I keep on struggling and manage to breathe before losing consciousness. However, he did it so hard that I can still feel, half an hour later, how my trachea is choked and there is no free breath passage. Experiencing both my father and mother trying to kill me makes me indescribably sad. I find it difficult to believe that this is true, not in a denial way, but in the naïve way, which is my way of surviving my parents' evil.

One side

On the other side

A repair: Black side:

Naïve, simple-minded towards

Believe people are worse than they actually are

People's evil intentions

He and she are going to kill me

When I told Søren on the phone he suggested I work at these disequilibria with my gestalt therapist.

Friday evening

The sentence “There is no room for me” comes to me. The sentence “I am nothing” re-appeared.

The night from Saturday to Sunday

Dream: I am in a garden together with two girl friends and another girl. We are two couples; we are chatting, going for a walk and having fun. At a window a women with her companion are making fun of the four of us and find we are very much “out of fashion” as lesbians, it’s just so “out”. They are making fun of us. Up in the apartment, the home companion is going to bed, and the women find that her companion is foolish and narrow-minded. As she looks uphill she sees her own father observing her from a big balcony. She herself is in her room, and he is looking down at her. Suddenly I am in her apartment, and we are lying together naked in her bed. It does not bother her that her father is disappointed that she is not giving him grandchildren. She wants to stay together with me and does not care about him. I am enjoying her; I am enjoying looking at her, touching her. She is just gorgeous, like a dream.

Sunday

I have got a particular sensation, I am in a special situation. Never before have I been experiencing so massive, so intense, so deep a gestalt. “She is going to kill me”, “He is going to kill me”, “They are going to kill me” are some really cruel gestalts. A moment ago, as I was talking with Søren on the phone, the sentence, which also came to me at the movie yesterday “It’s really serious” turned up. It contributed towards making the situation enormously heavy to me.

Søren said that the decisions we are making become our wishes as well, which – if not carried out at that time - will remain our wishes, which we want to carry out. Consequently, I wished to be killed, and this makes me attract people who wants to kill me. I attract the perpetrator. Right now I am feeling sorry for myself. Yuck, do release that too! I am releasing: “It’s really serious, I feel sorry for myself, she is going to kill me, he is going to kill me, they are going to kill me”. Søren told me that the universe is gracious and allows us all to commit mistakes once.

After supper, on Sunday

1) Rape: my paternal uncle in the bathroom. He holds me in a new and unpleasant manner, I almost hang, my head down, while he is shifting between the holes. It aches up to the navel; I am dizzy and have got nausea. Meanwhile I think that I will be going to the sink afterwards and vomit. He gets his orgasm in my mouth, and next I am squatting at the sink. The sentence “I feel so bad” comes up. At a point I am out of myself; I am going to faint and this because the pain is unbearable. I don’t know where I am; it’s dark. I am older, maybe 5-6 years.

2) Rape: my paternal uncle. The pain is completely unbearable. He is hammering and humping like a fool. It hurts indescribably. At a point he hits something up inside me, and it almost says “klonk”. What does he hit? It hurts so much! I am not able to scream, he is holding me. I cry from pain.

3) Ill-treatment: my mother in the bathroom. She is digging me out; huge pain. I almost jump every time she digs inside me. The movement is totally different than that of the men’s; she gets much more aggressive and is everywhere inside me. I can feel how the spoon is

scraping up my rectum. Now I go to the toilet, have diarrhoea, and I tell them: "It's fine you came, and now you must leave". Afterwards I am getting better.

My ex-boyfriend came in the afternoon and while we are doing the dishes, I told him that both my father and mother have tried to kill me, and that several of my family members have abused and raped me. He becomes terribly angry, because it is unbelievable that I am telling him this and that he is here, while I am reliving the three above episodes. I think that is why I relived such a huge pain; he loves me and backed me. I appreciate that. He is an invaluable support for me. I guess his purpose is: "I am good, warm and affectionate". The sentence "I am miserable" appeared during the conversation with Søren.

Monday

I am useless, I can nothing, I am so foolish. I feel like lying like a little baby in a cradle, being rocked, fed, changed. I want to be taken off. To be nothing and yet to be everything for myself, that makes me crazy. The black painting with the light stroke. You must paint it, Søren said. It represented how I was inside my mother's womb; she was coal-black, then I came and was lying in her uterus like a snow-white stroke.

Friday

I told him how my father had often been saying that my mother was a schizophrenic. Søren said that I had taken that in, and that my sentence was "She is a schizophrenic". That sentence did hardly want to leave my fingers! I had been taking it in so well that I had to make an effort, and I got easily short of breath when having to release it.

Earlier I had been talking on the phone with a friend, who was also grumpy, and I had told her that it felt as if I was at the bottom of a mash; muddy and turbid. After having let go of "She is a schizophrenic" Søren said I should let go of "I am a schizophrenic"; then indeed I started struggling. My defence had been moved into position; I told him that the sentence was not like that, and I resisted a lot. Of course, it proved to be the completely right sentence, and probably much more difficult to release than the earlier one. On releasing it, something fantastic happened. Suddenly it turned completely bright behind my closed eyes, and then followed a light. It became so wonderful inside me; it felt so indescribably well to be inside myself. Fantastic! And then I could say: I WAS a schizophrenic.

My friend was still cross and lovely at the same time. I briefed her on Monday's processing with Søren. I told her that I had been a schizophrenic, and it was so indescribably nice to share this with her. She did not become frightened or run away from me. She could easily have done that.

Wednesday evening I am dining out with my best friend and later we watched a movie at his place. It was a very tough movie on abuse. Afterwards I told him about Monday's episode. Damned if I did not tell him that I had been a schizophrenic!!! Well, I really did so, and while telling him I realized that his purpose of life was probably: I do contain.

Thursday

The following sentences turn up: I am getting ill now, I am useless, I don't care anymore, let me die, you don't care, I am ashamed, you must leave me alone, they must leave me alone, I am dying now, I am very scared. Suddenly I feel I get completely cleared inside of any struggle, discomfort and unpleasant feelings whatsoever. I suspect I jumped out of myself; how can it be so silent, quiet and nice inside myself? I simply cannot at all see or sense where I should have jumped. Therefore I think I still was in myself and that the peace was due to me having won the last and decisive battle against the ultimate evil! Then I got so sleepy that I had to lie down on the floor and rest for about half an hour. Next I sat up again and started

releasing. I went into them all, and “I am ashamed” and “I am very scared” (of what might happen to me; to get insane, etc.) were particularly tough. I sense, like I have been sensing the whole day that I have not even got a façade at all; that there is nothing I can use, I am completely nude. Anna was the borderline/schizophrenic girl, and now that I have released that, I feel I have got almost no personality! I have to define myself on a new, clean slate and from the beginning. Who am I? This appears a relevant question now... At home I take out the telephone. I do not know what to say to people, and I do not want to talk with Søren.

My girlfriend is visiting me, and I tell her sincerely how I have experienced not respecting her and that I want to apologize for that. I saw my lack of respect towards her expressed, because I never phoned her and took too long to reply to her messages on the answering machine, the same for her e-mails, and too many times I cancelled our appointments. Then I said that for this reason I find I have not been a friend, nor am I motivated/feel like being her friend, and that we should stop it here. Furthermore I tell her that I have the feeling of breaking a pattern of hers about always giving and not getting or wanting to receive anything in return. I say I do not want to help her maintaining that pattern of hers; neither she nor I deserve that. Although I had got red rings under my eyes after the day's massive, heartrending crying, I was feeling remarkably well as she visited me. What I said and did was feeling so right, and actually it was the first thing I felt right as an ex-schizophrenic, right indeed. It made me feel indescribably well to be so sincere towards her and conclude a malfunctioning friendship. I found it was really smart for my part.

In the evening the shame come up in me again and “I am very scared” comes also up again, and I let go of the sentence. However, it is as if I did not fully succeed in getting rid of the shame. Later I talk with my friend; she is tidying up too, and next we talk about my day's events. I told her then that I could feel in myself I had to go away for some days, to a strange place, where nobody knows me in order to be and get closer to an answer as to who I am. It feels right. I told her I wanted to go to the youth hostel in the north. She approved and said she found it felt right too. Furthermore we talked about my family name, because I was ashamed of it due to my father's family, and now I also feel Anna does not match. She asked me to think about some other names, about how I found them, and about what I find is matching. We discuss several options and it sounds great! Really beautiful and it feels right too. Yes it feels good, indeed.

Thursday night

I wake early in the morning. Friday morning; my heart is galloping, and I can feel I am afraid that Søren might get angry with me, about my reporting sick, about perhaps me not having contacted him at all for several days or him not being able to contact me. I am scared. At 5:30 am I phone him and leave a message that I am ill. Fall asleep until about 7 am and again sleep until 10 am. Then I start getting ready to leave for the north. It feels so right and as a necessity to leave for a couple of days. Now it is as if even the apartment makes me frustrated and I guess maintains me in a wrong image of myself. I was very much in a hurry to leave home today. In the train on my way up I got unwell. Thought again of Søren's probable anger; will he feel that I let him down, or will he think “All right, this was Anna, she was a schizophrenic; I am so happy to have got rid of her”? Now I am able to concentrate on the important things.

The sentence “I'm not important” comes up. Released, hmmm. I don't know about Søren; I'll see. From one train I transferred to a little train to go further and when getting off, I caught sight of the wonderful woods. My eyes filled with tears, and for a short while I was

enjoying getting overwhelmed by nature's beauty. What a gift, so wonderful it is, I am thinking. I find the youth hostel and have got about one hour and a half before checking in. I go down to the sea; it smells good of seaweed, it's windy. I sit a moment on a big stone and then can feel how the beautiful forest is pulling me in. I go up there again and get completely reabsorbed and warm inside by its beauty, how differentiated it appears in all its multicoloured autumnal glory and how spiced it smells. I take in all its beauty and have got to stop many times, just to enjoy the sight and the smell. I have got the feeling of being at the right place and of belonging to. I walk about and finally reach the top, up in the woods, and find (am pulled by it) a very fine spot on the coloured foliage carpet, among the woods' probably oldest trees. I look at them, smiling and then sit down among them. From there I have got the view over the woods, a few houses and the sea. A perfect spot, indeed! I'm feeling so fine there! I gathered various things from the woods to decorate my room, and by the way I am enjoying to the full nature's abundant and formidable grace, grandiosity and beauty. Perfect spot!

On getting my room I settle and lie down to rest/sleep. I'm up again in the evening and go down to eat in an Italian restaurant close by. From there I call my friend. She praised me a lot for having left and said that it is so brave and strong of me, just to sit down in the train and go and stay up there by myself. It also feels tough, actually. It has been hard as well. It is difficult to be in me, especially when having to relate to other people; for what am I going to say and what am I going to do? I know it will come little by little, that it just does not come at once, and that most likely a long period with a lot of nudity is awaiting me. I will cope with that too. Afterwards I walked down to the shore, in the woods as well as up on the road. I could sense that I have almost got rid of my strained relation to darkness. I could easily be in darkness at the seashore, walk through the dark woods down to the sea, and I was feeling fine. It is not completely okay, but I believe it will become. At the youth hostel I am writing in my bed. I have written 18 pages now, and it does me good to have got this whole story down on paper. It is always a relief for me to be writing about it, as if it does not any longer haunt me in the same way; thereby I get control of it. The image of a chicken, its head just broken through the shell, peeping at the world for the first time; like this I am feeling today. Now I am looking forwards like a new-born baby-bird; I see the world once more.

Saturday

After a nice bath I dressed and got ready to go out enjoying the nature. To begin with I must say that the sun has been shining on me the whole day; so beautiful and fine that I could not help saying hallo, while warming me on the outside and on the inside. This grew into many greetings. I was down near a Castle and was sitting at the end of the avenue with the sun on my face. The place was really beautiful and minimalistic. I proceeded a bit towards the city, but it was not the right way; too many cars, houses and first and foremost, too much noise. Therefore I went back and followed the beach with my recently purchased goods in the bag: chips and white bread, uhhmm. How great an outing it had been! I could sense how I got calmed and at the same time boosted from listening to the roar of the waves. I sat down on a big stone, on the cushion I had brought along, enjoyed the sound of the water and shuddered slightly at the warm sunbeams. While sitting there I thought of it once again: that I am an unwritten leaf and that right now I am exceptionally lucky, because I have got the chance to shape my life and myself like I want it. Now I can cultivate the capacities, skills and qualities I greatly prefer to possess, and this without the usual, rotten wreckage in tow, which could prevent me from doing it. There is a huge opportunity right now! I was also thinking this

means that now I will actually be capable of getting/achieving ANYTHING I want. I just have to set about getting/achieving it. I walked about 6 km, along the beach and walked back via the woods. I thought of the song “The woods around the country are turning yellow now” and changed the title into “The woods around the country are glowing now” because I find that was what they actually did. The woods are unbelievably beautiful right now, in fact my eyes filled with tears. It is indeed a huge gift for me to be up here in the beautiful nature. It was, no doubt, the completely right impulse to follow! As I returned I began to paint/colour a bit in the colouring book. However, it did not really mean anything to me though, so I did not finish the drawing. It was so boring ... Then I laid down to rest. I dreamed a little, but as I did not manage to maintain the dream, I forgot it again.

Now I have been taking a bath and I want to read a little, before going to sleep again. Tomorrow I shall check out in the morning. I am curious to know whether I will wake up, having got no watch. What I have been experiencing has been right: To stay in the pleasure: going for a walk today, giving myself in to the pleasure; not holding back at all and being able to stay in it. To give myself for: the anger. The same principle as for the pleasure: not holding back, being one hundred percent in it. - This is to be alive!

Saturday night

I twist about miserably in my bed, sweat as if I had got a very high temperature. The anger is huge, and while lying here I am full of it. I beat the mattress, swear, snub them, and then begin projecting anger onto Søren. I get angry with him at the way he treated me this week; the rough way mixed with an apparent indifference as to the way he had been reflecting me. Then the suicide thoughts appear:

- pistol: too much mess and too traumatic for those who find me
- cut my throat: same thing as with the pistol
- cut the wrists: then I shall suffer too long
- liquidation: I could pay someone to do it; this seems the best, until I am thinking of:
- overdose: which would be much better. A second later I think that I would probably

not know the correct dosage, but would brain-damage myself and end as a vegetable, dribbling and not even being able to communicate to people that they must kill me. Then Søren would call me, hold me close, and this would be the ultimate hell; me not being able to communicate, only dribble. Now I cry and am totally miserable. I still sweat fever. I think then: Stop – just be quiet. One day at the time. I say aloud: “I bring life and joy. I bring life. I bring life.” quite a lot of times, and this calms me; this slowly makes me relax. [Anna is here assuming responsibility for her own existence at the most deep level; she is facing the need to choose to live or to die, accepting life on its own conditions or not accepting it. This is really the deepest level of existential choice for any human being: do you want to live or do you want to die? And it is a strictly personal question; nobody can really help you out here, you need to solve this for yourself, as Anna instinctively did].

Monday

At long last I had a decent conversation with Søren. I had hurt his feelings, made him sad. He said I did it to create a distance between us. I told him that I was fond of him. He thanked and finished the conversation saying he was fond of me too.

Subjects: detachment, independence.

I slept very bad tonight, Søren and our understanding dialogue about “what did happen” the last few days being constantly in my thoughts. I even wrote a poem while shifting about restlessly.

Tuesday

I was at my gestalt therapist today. Further I am thinking that if I play my cards well I can end as something big. With my story, my intuitive intelligence and my courage I think I can become an entirely tough therapist. Watch me!

Later I talked with Søren; he was making fun of me and said I would soon be able to take my gestalt therapist in therapy. It was funny said, and I must admit that later on I will not forget her face, while telling her how I had been experiencing my therapy. Not only was she gaping, she also realized that she was facing a very intelligent girl, who had just discovered how intelligent she was. An educational experience, indeed!

Let me finish here by mentioning that my personal development will no doubt carry on. I have been releasing so amazingly much insecurity. Never before have I been feeling so confident that everything will turn out all right. I find I keep on getting ever more gorgeous, and I am sure I shall get the best boyfriend in the whole world. I am in the process of being quite happy; I am not miserable any more. I am convinced I shall become entirely happy.

Discussion

The major problem of working with incest or childhood sexual abuse patients using the four cardinal steps of holistic medicine

- Love
- Trust
- Holding
- Processing

is the extreme degree of closeness and intimacy this process involves. In this case representing the worst possible abuse over a long period in childhood, there is hardly a feeling that has not been felt and hardly a spot on the patient's body that has not been touched by the abuse.

To do this in an ethical way, a strict ethical code must be followed (1,25,26,31-33), but actually more than this, a deep ethical contemplation is needed to adapt existent ethical theory to the holistic medical clinic. Today, there are three main lines of ethics:

Normative ethics, setting the fundamental standards, is a most important subject for medicine and the physician and when it comes to the holistic medicine ethics it is not only a means for securing that the patients is not suffering any harm – the first Hippocratic demand to the physician was: do no harm – but it is also a primary condition for the holistic medicine to work in the clinic. The reason for this is, that only a totally focused intent to help the patient and to be at his or her service can make the changes in the patient's existence and consciousness correlated to the holistic process of healing. So, in a way, the ethical perspective, the goodwill and intention of being at service for the patient is what helps. In a way it is a much more simple task in bio-medicine, when it comes to quality control, because if the examination is done correctly, the diagnosis right and the medication with advice according to the book, then the “pneumonia” is optimally treated. In consciousness-based medicine it is not so simple. If you meet a patient without respect, you lose the trust of the

patient, and the cure will not work. It is as simple as that. So if you are not intending respect, you will fail. You will also fail, if you are not aware, careful, accepting, or acknowledging the true nature of the patient. And you will fail, if you are not able to support your patient in feeling, understanding or in letting go of negative beliefs. So actually, holistic medicine is an art based on ethics, while bio-medicine to a large extent is a skill based on mental knowledge and intelligence. How does the ethics of holistic medicine fit to ethical theory? This is not a simple question to answer.

Teleological ethical theory, the one of the philosophical main ethical positions, focused on consequences and claim that what is obtained by an act is the essential. The deontological position, on the other hand, is about duty and claims that the intention is what really counts. It is very interesting, that because we are dealing in a way directly with consciousness and experiences, the teleological and the deontological position are both true at the same time, in holistic medicine. The intention creates the result, and actually the result mirror the intent. This is fairly true, when it comes to holistic healing, but it is not true in absolute terms. If I intent to help a patient mortally ill with cancer and I prolong the sufferings without creating any good for the patient, I have had good intensions, but my results were bad. Sometimes this problem is solved by asking the patient what he or she wants, but the duty-ethical position is that deep inside every life has the wish to live; the patient might take the position of the ego, not his true self and so he is tricked and the physician, following this patient's verbally expressed choices, is tricked as well. Therefore suicide is not a good idea. Interestingly, the two different approaches to ethics can be seen as either a preference for power – what can be obtained - or a preference for love and purpose. But there seems to be one more fundamental dimension in human existence, and that is gender, or sexuality, and the balance between these two.

The feministic ethics arise from the third position, claiming that the two genders carry two different sets of values: It is necessary to be conscious of these two very different sets of human values, for if you happen to exclude one set, you will pull or push reality out of balance, and the intended value cannot be realised. In holistic medicine this argument seems to be extremely important, in that the classical female values – represented by the qualities of holding – is to be complemented by the set of classical male values – represented by the qualities of processing. It is important to understand that these qualities are not bound to sex or gender in a simple way and the holistic physician can provide both male and female qualities. He can be “the good mother” for a patient, who never had one, to heal the early wounds of failure, scolding or neglect. A core idea for the Jungian inspired holistic medicine is that everybody contains both the male and the female, and only if both parts are understood, accepted and integrated, can the human being – patient as well as physician – be a whole, healthy, talented and happy person. Interestingly, many of the “bad” things physicians have done in the best of intentions (34), like clitoridectomy as a treatment for “nymphomania”, can be understood as a result of the feminine values not being sufficiently represented.

Clinical work with incest and other sexually abused patients have forced us to put much more focus on gender and sexuality, as many problems are found here symptomatically, and as many more arises from the lack of joy and pleasure coming from the patient not being in balance on the male-female axis (35). Our ethical position is now a balanced view between these three extreme ethical positions. We must have the best of intentions, but we must also look carefully at our results, not harming our patients. We must be loving and powerful, but

we cannot ignore the dimension of gender and sexuality, how impractical and hard-to-integrate-with-hard-medical-science such dimensions might appear.

The holistic physician is, like any other physician in any medical paradigm, free to choose any of the three philosophical positions of ethics, but maybe there is one clear ethical position that will be of most benefit to the patient. To explore this different field of ethics is an important part of the job to be done in future papers on holistic medical ethics. Some of the main arguments of Emanuel Kant, John Stuart Mill and the feminist thinkers must be discussed in this connection.

There is also the problem of normative ethics: it varies from culture to culture, so what is the universal applicability of clinical holistic medicine? For example, the use of touch and acupressure through the vagina are basically unacceptable in the Asian cultures. The universal applicability seems to be that loving care, trust, holding and processing can be a part of any treatment, anywhere on the planet. The degree of intimacy must always be adjusted to the actual culture and the local legal requirements. As some of the procedures involve close physical contact between the therapist and the patient, how can we ensure that the therapist is not exploiting the patient in the process? This is one of the most important questions, but sexual exploitation is fairly simple to avoid as sexual behaviour between the physician and his patient is forbidden ever since Hippocrates. But there are other more subtle, emotional kinds of exploitation, i.e. the physician wanting confirmation or admiration from his patients, treating them in ways to obtain that. The only way to avoid this is by strict supervision; the supervisor is much more likely to observe power-games and unwanted transference and counter-transference than the physician or therapist him- or herself.

Another important question is, if the more physically intimate procedures are consistent with the code of practice of the mainstream medical and counselling associations in the Western world? Many counselling associations in psychiatry, psychology and cognitive therapy prohibit counsellors to have physical contact with clients of the opposite sex and touching the clients' genitals is strictly prohibited. On the other hand, there are many organisations of body workers that stress the importance of intimate physical contact in the therapy. As the clinical holistic medicine toolbox is not yet endorsed by the mainstream, we need to alert the readers that the related procedures are more or less controversial in nature, in all therapeutic fields, where bodywork are not usual.

Finally, what are the limitations of using verbal reports to support the claim that the intervention is successful? It is important to understand that both the therapist and the patient must in the end feel that the therapy has been successful. Such verbal reports do not necessary prove that the therapy is going well, but at all times the therapist must follow the patient from an objective position and evaluate how the presented written material from the patient can be understood. If the patient considers life is worth living, the therapist should evaluate carefully if the patient have any tendency to commit suicide. Very often the written words in the patient's diary are expressing strong feelings and deep existential thoughts that in another context, i.e. a suicide letter from a desperate teenager, would mean the highest alert. In therapy, where the feelings are expected and the process is in full control, even expressed thoughts of committing suicide almost never indicate that the patient has such actual plans. The diary is simply about containing and integrating the unbearable feelings from the past.

Conclusion

Anna's story showed us what it takes to heal from extreme severe sexual abuse for years of her early childhood. It is really amazing that she managed to continue her process of healing even when the emotional pain get worse. The secret was the environment with so many people that wanted to help her, her courage to open up and accept to receive the help she needed. Anna's life would undoubtedly have been a life in and out of mental institutions, if she had not done this great work of healing. It is important to stress that it was Anna, who did the work herself; she wrote hundreds of pages of diary, she worked for many hundreds of hours on letting go of hundreds upon hundreds of negative decisions taken in the painful events of abuse.

The role of the physician is as the good and patient father, who gives the patient the love, care, awareness, respect acknowledgment and acceptance that she needs so badly, because she never received it from her own father or mother, who just did all the wrong things in one long series of extremely painful and systematic traumas.

What is to be learned from this story is that almost any patient can heal, when giving the proper support. We believe that the support must be holistic in its approach to mobilize the necessary resources for healing. The holistic process theory of healing gives a good model of this healing; a source to unlimited resources seems to be the recovery of the purpose of life (29,36-42) and working with this in the therapy seems to be what motivated Anna and kept her going in spite of all odds.

We are honoured to have worked with Anna and we send her all our best wishes for the future, which we actually expect to be excellent. Because of all the existential pain, where you take responsibility, will end as learning, insight and give you wisdom to love, forgive and lead a rich, full and successful life. We believe that Anna will get much more out of life, than a normal girl who never was abused and never healed her existence from the most fundamental level. The lesson for us all is to learn from Anna's history, which she so generously has shared with us. Life is really nice, strong and intrinsically valuable that even the darkest of event and the most evil of men cannot really destroy. As long as the body is intact the person inside can heal, but only in love.

Most importantly, Anna and many patients after her have demonstrated that in spite of the depth of the existential crisis, holistic existential therapy seems to support existential responsibility so well, that the therapy is very safe for the patients. With more than 500 patients treated with holistic existential therapy at the Research Clinic for Holistic Medicine and Sexology in Copenhagen, we have never experienced a single patient, who has tried to commit suicide during or after therapy.

Neither have we seen a patient, who developed a mental illness provoked by the treatments, because the existential crisis is always temporary. This implies that holistic existential therapy is safer than standard biomedical psychiatric treatment.

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Rehabilitation of philosophy of life during holistic existential therapy for childhood sexual abuse

When we experience life events with overwhelming emotional pain, we can escape this pain by making decisions (in our mind) that transfer responsibility from our existence to the surrounding world. By doing this, we slowly destroy the essence of our being, health, quality of life, and ability to function. The case of Anna is an excellent example of such a systematic destruction of self, done to survive the extreme pressure from childhood abuse and sexual abuse.

The case study shows that the damage done to us by traumatic events is not on our body or soul, but rather our philosophy of life. The important consequence is that we can heal our existence by letting go of the negative decisions taken in the past painful and traumatic situations. By letting go of the life-denying sentences, we come back to life and take responsibility for our own life and existence.

The healing of Anna's existence was done by existential holistic therapy. Although the processing did not always run smoothly, as she projected very charged material on the therapists on several occasions, the process resulted in full health and a good quality of life due to her own will to recover and heal completely.

The case illustrates the inner logic and complexity of intensive holistic therapy at the most difficult moment, where only a combination of intensive medical, psychiatric, and sexological treatment could set her free. In the chapter, we also present a meta-perspective on intensive holistic therapy and its most characteristic phases.

Introduction

In order to find a way to rehabilitate victims of childhood sexual maltreatment, many forms of therapy have been used (1-14), but not always with satisfactory results. Therefore, we needed to take the more radical and confrontative methods and therapeutic tools of the classical Hippocratic sexological clinic into use. We did this to facilitate the important process of

existential, emotional, mental, and sexual healing that can take the patient all the way back to a normal life.

We have often seen such a treatment successful in the end in spite of our deep scepticism at the beginning of the treatment, because of the patient's very poor state of being. We therefore believe it is important to analyze and reflect over the journeys of a long and often difficult treatment process for these patients.

Anna was a borderline patient (15-17), student, 22 years of age, who had completely repressed over 100 episodes of childhood sexual abuse. She has recovered completely, including regaining her full emotional range, through holistic existential therapy (18), individually and in a group (19,20). The therapy took 18 months and more than 100 hours of intensive holistic existential therapy.

In the beginning of the therapy, the issues was her physical and mental health (21,22); in the middle of the therapy, the central issue was about her purpose of life (23) and her love life; and at the end of the therapy, the issue was about gender, character, spirit, and sexuality.

The strategy was to build up her strength for several months, mobilizing all her hidden resources and motivation for living, before the painful old traumas were confronted and integrated. The therapy was based on the quality of life philosophy (24-31) and theoretically based on the life mission theory (23), the theory of ego (32), the theory of talent (33), the theory of the evil side of man (34), the theory of human character (35) and the holistic process theory of healing (18).

The clinical procedures included conversational therapy and training in philosophy of life (36). The tools in use were the advanced holistic medical toolbox and the group therapeutic tools (19), extended use of therapeutic touch (37), holistic pelvic examination (38,39), acceptance through touch (40) and acupressure through the vagina (41) in order to integrate the early traumas bound to the pelvis and scar tissue in the sexual organs.

The therapy had two phases; the first was a normal phase, where the patient was integrating old material destabilizing her mental state (21,22). After months of therapy, she broke through to a layer of repressed material revealing substantial sexual abuse. The traumas started as physical replay of rape traumas followed by the associated emotions and feelings, and finally came her insight and understanding, leading her to identify and let go of hundreds of negative sentences, the content of which is the issue of this chapter.

It seems as if she worked her way up the scale of existential responsibility, from the hallucinated state in the bottom to the free and responsible state at the top of the scale (see table 1) (22). The scale describes how existential responsibility — seen from inside (the state of consciousness) and outside (the behaviour) — is first lost and then found as the patient climbs the ladder of hallucination, blacking out, denial, escape, psychic death, unbearable emotional pain, to freedom of perception. To rehabilitate a psychotic patient in a hallucinatory state of consciousness, you need to help him or her confront the trauma that originally motivated the escape into hallucination. In doing this, you must carefully avoid pushing them deeper down into suicide (22).

Just before the end of the therapy, Anna had a severe existential crisis, where she confronted the value of her own life and she decided to live and accept life as it is, including the shadow of herself and the experiences of evil in her personal history. Interestingly, when she was healed at the end of therapy, she had to go to the bottom of the scale to confront death with her totality, to finally win life and assume full responsibility and her freedom, which was lost in the past.

Table 1. Responsibility for life scale

Degree of responsibility for your own existence (Estimated Percentage)	State of Consciousness (Many Substates Exist)	Behavior (Other Patterns Might Exist)
100% responsibility Mentally healthy	Present, fully aware, interpreting the world according to your purpose of life	Succeeding, playing
90–80%	Emotional pain (denying and repressing the feelings)	Fighting, attacking
66% Neurotic	Emotionally overwhelmed, psychic death (denying the purpose of life)	Fighting, defending
50%	Escaping from here and now	Flight, running
40%	Cannot escape, denying here and now	Freezing, helplessness
33% Psychotic	Destructing the perception (wiping out, “blackness”, “closing eyes”, denying the mind)	Shocked, numb, lame
20–10% Hallucinating (substituting perception)	Dreaming (perception and behavior not related to the outer world)	Dream state
0% responsibility Dead	Unconscious, in coma (denying the body)	Physically dying, suicidal, evil and destructive

The negative, life-denying decisions

Table 2 is a list of the most important negative and life-denying sentences that were released during the therapy. The sentences were the essence of the gestalts that were integrated in the therapy; they are both feelings and thoughts at the same time, making them extremely to the point of the experience. In Table 3, the sentences are listed according to the responsibility for life scale.

Treatment method

The case of Anna illustrates the inner logic and complexity of intensive holistic therapy, when it comes to be most difficult, where only a combination of intensive medical, psychiatric, and sexological treatment could set her free. The treatment was intensive existential holistic therapy with the theories of sexuality used to structure and interpret the elements and phases of the therapy strongly inspired by Freud, Jung, Reich, and Lowen (16,17). The focus on unconsciousness and the use of terms such as “projection” (transference) is an example of the (neo-) Freudian perspective.

The therapy started with addressing the layer of “quality of life-health-ability”; the next steps addressed the issues of love, consciousness, and sexuality and the third, final, and deepest layer of existential coherence. The patient ran through a series of steps in her personal process of metamorphosis (see figure 1) with three severe existential crises during the therapy:

- A psychotic crisis where the content of the stream of consciousness looked psychotic, while the patient was still with a part of her consciousness in present time, still able to perform normally, stayed in contact with the world and therefore not psychotic in the classical, psychiatric sense of the word. This was a necessary, but very painful phase of the therapy, where she integrated an old psychotic state of consciousness from her tormented childhood dominated by violence and sexual abuse.
- A visionary crisis where she understood her true nature as a human being and “remembered” the collective consciousness of mankind. In this phase, she “plugged” into being human again.
- A suicidal crisis where the content of the stream of consciousness looked like she wanted to die, while the patient also here with a part of her consciousness stayed in present time, still able to perform normally, to stay in contact with the outer world and therefore neither psychotic in the classical, psychiatric sense.

Table 2. The most important sentences Anna let go of in her holistic existential therapy (as they appeared in the therapy)

1.	I trouble other people	40.	There is nothing to come after	75.	I am worthless, am I not?
2.	I am troublesome			76.	I hate her
3.	I am a burden	41.	It is absurd	77.	I loathe her
4.	I am impossible	42.	When I come, I am dying	78.	She is nasty
5.	It is my fault	43.	I cannot stand having it inside me	79.	She is disgusting
6.	I am not good enough			80.	I am a failure
7.	I do not deserve to live	44.	I cannot find my bearings at all	81.	I am out in the space
8.	I do not deserve life			82.	I have failed
9.	I have clocked out	45.	This is the worst thing you have done to me	83.	I cannot be in myself
10.	This is unreal			84.	I want to leave
11.	I am empty	46.	He is a pig	85.	I am worthless
12.	I am hollow	47.	He disgusts me	86.	Could he think of anything sexual?
13.	I want to go away	48.	He scares me		
14.	I want to live	49.	He is like them	87.	Nobody is there for me
15.	I get relieved	50.	I do not care	88.	I am miserable
16.	I decide – never mind	51.	I bet you will get it!	89.	Now it is enough!
17.	She does not want to	52.	He is cold	90.	I cannot give birth to my child like that. – It will be a trauma for the baby
18.	I do not want to hear it – ever	53.	He is disgusting	91.	He is going to kill me
19.	I do not hear it	54.	He does not care	92.	There is no room for me
20.	I do not want to know it	55.	He is so violent		
		56.	If you tell it to anybody, nobody will want to have you		
21.	I do not want to say it	57.	I have got nobody	93.	I am nothing
22.	It is not my fault			94.	She is going to kill me
23.	This is not OK			95.	It is really serious
24.	This is my secret	58.	It's really bad	96.	I feel sorry for myself

25.	You should just know that you will be punished, harder then ever, if you tell it	59.	I want to die	97.	They are going to kill me
		60.	I cannot have this	98.	I feel unwell
		61.	Unbearable pain	99.	It is fine you came, and now you must leave
26.	It is not me	62.	Why didn't they kill me?	100.	I am good, warm and affectionate
27.	I do not want to	63.	You bet I will get it out	101.	She is a schizophrenic
28.	You get punished	64.	I cannot do that	102.	I am a schizophrenic
29.	I do not want to hear it	65.	I get smashed up		
30.	I can do nothing	66.	I go to pieces	103.	I am ashamed
31.	I cannot stay anywhere	67.	I will ...		
32.	I bring warmth and joy	68.	Be careful/do it carefully	104.	I am very scared
33.	I am ugly	69.	It is not so bad	105.	I am not important
34.	I am afraid of men	70.	I do not want any more	106.	I bring life and joy
35.	I feel sorry for myself	71.	Nobody likes me	107.	I bring life
36.	She is too much	72.	It is odd	108.	What did happen?
37.	I am getting punished	73.	It is really curious		
38.	I do not need you	74.	I am not good, am I?		
39.	I need nobody				

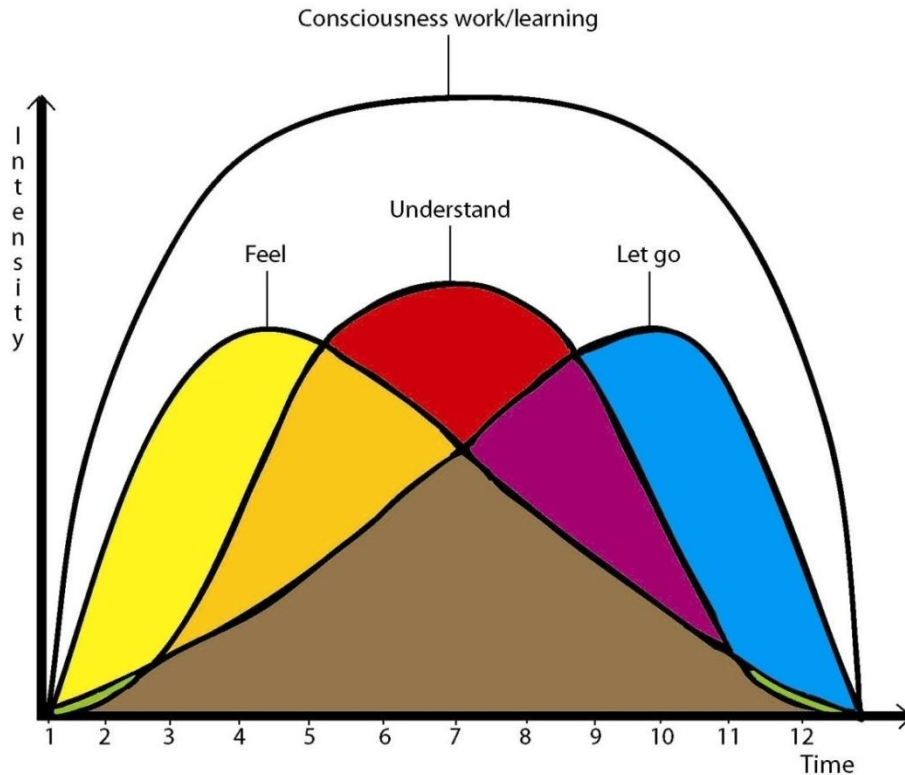
*While letting go of these decisions, she healed her existence and recovered from a dysfunctional state caused by about the similar number of sexual abuse events in her childhood, including rape.

Table 3. The organization of the sentences of denial of her life in the many different existential dimensions (33) fits to the scheme of the responsibility scale and the degeneration of perception

90% Responsibility		Emotional Pain (Denying and Repressing the Feelings)		Defending	
1.	I have failed	16.	I am ugly	24.	I am worthless, am I not?
2.	Could he think of anything sexual?	17.	I am afraid of men	25.	I hate her
3.	I cannot give birth to my child like that. – It will be a trauma for the baby	18.	I feel sorry for myself	26.	I loathe her,
4.	I am good, warm and affectionate	19.	It is really bad	27.	She is disgusting
5.	I trouble other people	20.	Unbearable pain	28.	I am worthless
6.	I am troublesome	21.	I do not want any more	29.	I am miserable
7.	I am a burden	22.	It is not so bad	30.	I feel so unwell
8.	It is my fault	23.	I am not good, am I?	31.	I am ashamed
9.	I am not good enough			32.	I am very scared
10.	I do not deserve life			33.	I am not important
11.	She does not want to				
12.	It is not my fault				
13.	This is not OK				
14.	I do not want to				
15.	I bring warmth and joy				

Table 3. (Continued)

50% Responsibility		Emotionally Overwhelmed, Psychic Death (Denying the Purpose of Life)		Fighting	
34.	I want to live	40.	I cannot stand having it inside me	46.	I want to go away
35.	I get relieved			47.	I cannot have this
36.	You get punished	41.	I cannot find my bearings at all	48.	Nobody likes me
37.	She is too much			49.	I want to leave
38.	I am getting punished	42.	He disgusts me	50.	Now it is enough!
39.	When I come, I am dying	43.	I do not care	51.	It is really serious
		44.	I have got nobody		
		45.	I want to die		
40% Responsibility		Escaping from Here and Now		Flight, Running	
52.	I have clocked out	55.	I don't hear it	59.	I can't stay anywhere
53.	I decide NEVER MIND	56.	I don't want to know it	60.	I am out in the space
54.	I do not want to hear it - ever	57.	I don't want to say it	61.	I cannot be in myself
		58.	I don't want to hear it		
30% Responsibility		Cannot Escape, Denying Here and Now		Freezing, Helplessness	
62.	I am hollow	68.	He is a pig	75.	You bet I'll get it out
63.	It is not me	69.	He scares me	76.	I cannot do that
64.	I can do nothing	70.	He is cold	77.	I will ...
65.	I do not need you	71.	He is disgusting	78.	Be careful/do it carefully
66.	I need nobody	72.	He does not care	79.	It is odd
67.	There is nothing to come after	73.	He is so violent	80.	It is really curious
		74.	If you tell it to anybody, nobody will want to have you	81.	I bring life and joy
				82.	I bring life.
				83.	What did happen
20% Responsibility		Destructing the Perception (Wiping Out, "Blackness", "Closing Eyes", Denying the Mind)		Shocked, Numb, Lame	
84.	This is unreal	88.	He is like them	89.	I am a failure
85.	I am empty			90.	There is no room for me
86.	This is a secret			91.	I am nothing
87.	You should just know that you will be punished, harder than ever, if you tell it			92.	It's fine you came, and now you must leave
10% Responsibility		Hallucinating(Substituting Perception)		Dreaming (Perception and Behavior Not Related to the Outer World)	
93.	It is absurd	94.	She is a schizophrenic	95.	I am a schizophrenic
0% Responsibility		Unconscious, in Coma (Denying the Body)		Physically Dying, Suicidal, Evil and Destructive	
96.	I do not deserve to live	99.	Why didn't they kill me?	103.	He is going to kill me
97.	This is the worst thing you have done to me	100.	I get smashed up	104.	They are going to kill me
		101.	I go to pieces		
98.	I bet you will get it!	102.	She is going to kill me		



The phases of adult human metamorphosis

- | | |
|--------------------------------------|------------------------------|
| 1) Philosophical opening phase | 7) "Suicidal" crisis |
| 2) Therapeutical beginning | 8) Integrative phase |
| 3) Therapeutic "pre-psychotic" phase | 9) Philosophical integration |
| 4) "Psychotic" crisis | 10) Secondary breakthrough |
| 5) Visionary phase | 11) Re-entry |
| 6) Primary breakthrough | 12) Re-adjustment of life |

Figure 1. The process of holistic healing seen as three phases of feeling (yellow), understanding (red), and letting go (blue) of negative beliefs, attitudes, and decisions. As an end result, the process was improving the patient's philosophy of life and thus allowed the patient to rebalance existence and to assume responsibility for life. During the process, the patient's will re-established quality of life, health, and existential coherence, along with the ability to love, understand, and enjoy the whole spectrum of feelings and emotions, including sexuality. Many patients in intensive therapy experience the healing as a series of phenomena or breakthroughs and existential crises with characteristic content. The most intense crises are metaphorically called the "psychotic", the "visionary", and the "suicidal" crises. They include feelings of going insane, not knowing the world or oneself, and wanting to die. Knowing what is coming next in the course of therapy is of great help to the patient, making it much easier to confront and integrate the often extremely intense, painful emotions and states of being, arising from integrating the early childhood traumas. The 12 steps (see figure) are some possible steps in the process of healing and human transformation; understood though an ancient and powerful metaphor as the steps of "human metamorphosis".

The intensity of her therapy followed a bell shaped curve (see figure 1) with a lot of minor arches rising and falling though the therapy. Interestingly "the tone or melody" of the processes changed during the process, from being dominated by painful emotions in the beginning, to understanding and revelation in the middle of the therapy and a focus on philosophy and "letting go" of negative beliefs in the end (see figure 2).

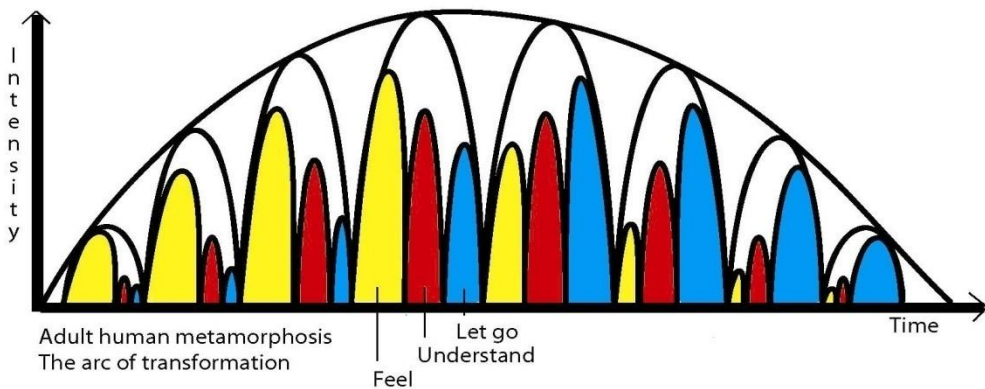


Figure 2. The arcs of transformation. The intensity of emotion, mental learning, and philosophical development follows a typical pattern in intensive holistic therapy (we use the metaphor “adult human metamorphosis”).

There are several methodological problems in using the Responsibility of Life Scale. First, the best way of operationalization has not yet been fully explored. Second, it would be necessary to know the inter-rater reliability of the scale before the scale could be meaningfully used in the clinical context. Interestingly, this pattern of “metamorphosis”, taking the patient from being like “the butterfly’s larvae” into the transformations state of pupae, finally into being the butterfly she was originally meant to be, seems to be so characteristic that the dominating quality of “feel-understand-let go” indicates where the patient is in the course of the therapy. This is very important as we often need a clue to find out, if there is more important, hidden material in the subconsciousness of the patient, so that therapy can be terminated. To create table 2 and table 3 was not so easy. Basically, we still need a systematic coding system to categorize the responses and we also need to prove that the responses have been coded in an objective manner. The presented meta-perspective of the therapy of Anna is therefore still a qualitative approach to understanding the process of intensive, holistic healing.

Discussion

The findings of these negative decisions and the content of these seem to be in agreement with the holistic process theory (18) and the holistic theory of mental illnesses (21,22). The organization of the sentences according to the steps of the Responsibility for Life Scale was less successful, but still doable. The decay of existence seems to happen somewhat chaotically; the timeline of the appearance of the sentences in the therapy did not reveal much structure, as sentences with all kinds of content revealed themselves as disorderly and chaotic. It seemed that the destruction of life was done extremely creatively in every situation as a reduction, which then solves the problem in every case. It is very interesting that many different sentences can coexist and that the person has the resources to come back again and again, while still carrying the destructive sentences in her unconsciousness.

It seems fair to assume that the load of negative beliefs revealed by the therapy could have the effect of making Anna severely mentally ill, even schizophrenic, and that the integration of this material saved her mental health and general well being for life. When we experience life events with overwhelming emotional pain, we can escape this pain by making decisions in our mind that transfer responsibility from our existence to the surrounding world. By doing this, we destroy our being, our health, our quality of life, and our ability to function little by little. The case of Anna is an excellent example of such a systematic destruction of self, done to survive the extreme pressure on her existence from three men sexually abusing her systematically during many years of her childhood. The most surprising aspect revealed by the study of Anna's case is that the damage done to us by traumatic events is not on our body or our soul, but on our philosophy of life; the way we see and describe our world, life, our self, other people, and the world at large. The important consequence of this understanding is that we can heal our existence by letting go of the negative decisions taking in the painful and traumatic situations. By letting go of these life-denying sentences, we come back to life and to our natural responsibility for our own existence. We do not come back as a weak and wounded person; on the contrary the real magic of life is that we seem to heal completely and in an absolute sense. We are able to wash all dirt from our bodies and minds, we are able to recover our character and our purpose of life, we are able to return to the brilliant state of being a free soul, and everything that happened, when fully integrated, will not affect us anymore. The holistic healing of Anna's existence was done by existential holistic therapy. Although the processing did not always run smoothly, as she on several occasions projected very charged material on the therapists, the process ran all the way to full health and a good quality of life, thanks to her own will to recover completely. She wanted to be happy, she decided to take the process all the way to her personal happiness, and this was what made her keep working, until the day she could leave the clinic as a whole and renewed woman.

In our clinical experience, the advanced holistic medical toolbox has the tools needed for integrating even the most horrible of life events and traumas. The combination of holistic psychiatry, sexology, and rehabilitation was successful with even the most difficult and damaged of patients. Even when the patient was mentally ill and severely abused both violently and sexually during many years of her childhood, she could recover fully when she found love, trust, support, and holding enough to heal her existence and in this process, identify and let go of all her negative life decisions and systematically improve her philosophy of life. A "psychotic crisis" in the middle of the therapy seemed to be a good sign of healing and a "suicidal crisis" at the end of the therapy seemed to be a sign of the patient taking responsibility over her own life.

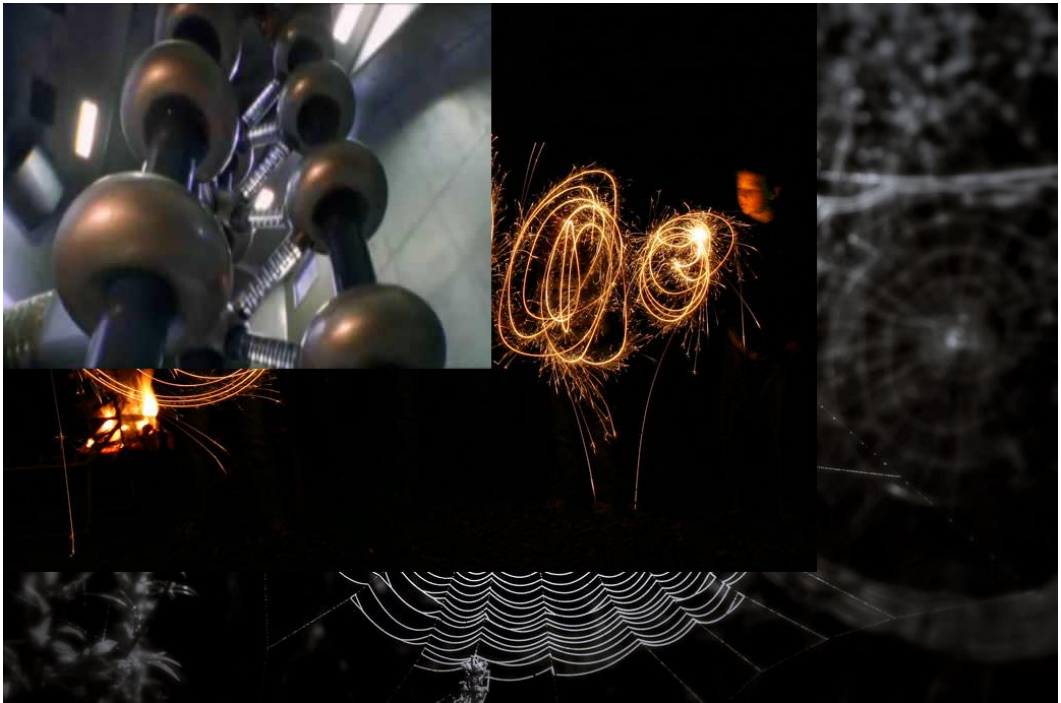
It is important to underline that in spite of the dramatic metaphors of "psychosis" and "suicide", these metaphors address the content of her consciousness, not her general state of being; she was thus not psychotic in the classical psychiatric meaning of the word at any time during the therapy. After Anna, we have taken dozens of patients through similar processes without seeing any of them being endangered or harmed. This is very important, as this is the primary reason why even the most intensive, holistic existential therapy is completely safe for the patient, in spite of confronting the most horrible of feelings.

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Section 2. Acknowledgments



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International review board

This book is written by Søren Ventegodt and Joav Merrick and the result of more than ten years of work together, but also an international collaboration with a group of very special people that we have published many papers with. This book project (a total of six books on mind-body medicine) has been a tremendous effort and we have been guided, helped and supported by a group of international collaborators and colleagues. These busy academics and clinicians have given of their time and expertise to advise us, so we wish to acknowledge their incredible support and friendship in this endeavor.

Andersen, Niels Jørgen

Andreasen, Tove

Anyanwu, Ebere C (deceased)

Bassaine, Laila

Brom, Bernard

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Kanu, Ijeoma

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Merrick-Kenig, Efrat

Morad, Mohammed

Nielsen, Maj Lyck

Neikrug, Shimshon

Omar, Hatim A

Orr, Gary

Rald, Erik

Struve, Flemming

Shek, Daniel T L

Torp, Margrethe

Thegler, Suzette

About the Quality of Life Research Center in Copenhagen, Denmark

The Quality of Life Research Center in Copenhagen was established in 1989, when the physician Søren Ventegodt succeeded in getting a collaboration started with the Department of Social Medicine at the University of Copenhagen in response to the project “Quality of life and causes of disease”. An interdisciplinary “Working group for the quality of life in Copenhagen” was established and when funds were raised in 1991 the University Hospital of Copenhagen (Rigshospitalet) opened its doors for the project.

The main task was a comprehensive follow-up of 9,006 pregnancies and the children delivered during 1959-61. This Copenhagen Perinatal Birth Cohort was established by the a gynecologist and a pediatrician, the late Aage Villumsen, MD, PhD and the late Bengt Zachau-Christiansen, MD, PhD, who had made intensive studies during pregnancy, early childhood and young adulthood. The cohort was during 1980-1989 directed by the pediatrician Joav Merrick, MD, DMSc, who established the Prospective Pediatric Research Unit at the University Hospital of Copenhagen and managed to update the cohort for further follow-up register research, until he moved to Israel. The focus was to study quality of life related to socio-economic status and health in order to compare with the data collected during pregnancy, delivery and early childhood.

The project continued to grow and later in 1993, the work was organized into a statistics group, a software group that developed the computer programs for use in the data entry and a group responsible for analysis of the data.

Quality of Life Research Center at the university medical center

The Quality of Life Center at the University Hospital generated grants, publicity with research and discussions among the professionals leading to the claim that quality of life was significant for health and disease. It is obvious that a single person cannot do much about his/her own disease, if it is caused by chemical defects in the body or outside chemical-

physical influences. However, if a substantial part of diseases are caused by a low quality of life, we can all prevent a lot of disease and operate as our own physicians, if we make a personal effort and work to improve our quality of life. A series of investigations showed that this was indeed possible. This view of the role of personal responsibility for illness and health would naturally lead to a radical re-consideration of the role of the physician and also influence our society.

Independent Quality Of Life Research Center

In 1994, The Quality of Life Research Center became an independent institution located in the center of the old Copenhagen. Today, the number of full-time employees have grown. The Research Center is still expanding and several companies and numerous institutions make use of the resources, such as lectures, courses, consulting or contract research. The companies, which have used the competence of the research center and its tools on quality of life and quality of working life, include IBM, Lego, several banks, a number of counties, municipalities, several ministries, The National Defense Center for Leadership and many other management training institutions, along with more than 300 public and private companies. It started in Denmark, but has expanded to involve the whole Scandinavian area.

The center's research on the quality of life have been through several phases from measurement of quality of life, from theory to practice over several projects on the quality of life in Denmark, which have been published and received extended public coverage and public impact in Denmark and Scandinavia. The data is now also an important part of Veenhoven's Database on Happiness at Rotterdam University in the Netherlands.

New research

Since The Quality-of-Life Research Center became independent a number of new research projects were launched. One was a project that aimed to prevent illness and social problems among the elderly in one of the municipalities by inspiring the elderly to improve their quality of life themselves. Another a project about quality of life after apoplectic attacks at one of the major hospitals in Copenhagen and the Danish Agency for Industry granted funds for a project about the quality of work life.

Quality of life of 10,000 Danes

There is a general consensus that many of the diseases that plague the Western world (which are not the result of external factors such as starvation, micro-organisms, infection or genetic defects) are lifestyle related and as such, preventable through lifestyle changes. Thus increasing time and effort is spent on developing public health strategies to promote "healthy" lifestyles. However, it is not a simple task to identify and dispel the negative and unhealthy parts of our modern lifestyle even with numerous behavioural factors that can be readily

highlighted harmful, like the use of alcohol, use of tobacco, the lack of regular exercise and a high fat, low fibre diet.

However there is more to Western culture and lifestyle than these factors and if we only focus on them we can risk overlooking others. We refer to other large parts of our life, for instance the way we think about and perceive life (our life attitudes, our perception of reality and our quality of life) and the degree of happiness we experience through the different dimensions of our existence. These factors or dimensions can now, to some degree, be isolated and examined. The medical sociologist Aaron Antonovsky (1923-1994) from the Faculty of Health Sciences at Ben Gurion University in Beer-Sheva, who developed the salutogenic model of health and illness, discussed the dimension, “sense of coherence”, that is closely related to the dimension of “life meaning”, as perhaps the deepest and most important dimension of quality of life. Typically, the clinician or researcher, when attempting to reveal a connection between health and a certain factor, sides with only one of the possible dimensions stated above. A simple, one-dimensional hypothesis is then postulated, like for instance that cholesterol is harmful to circulation. Cholesterol levels are then measured, manipulated and ensuing changes to circulatory function monitored. The subsequent result may show a significant, though small connection, which supports the initial hypothesis and in turn becomes the basis for implementing preventive measures, like a change of diet. The multi-factorial dimension is therefore often overlooked.

In order to investigate this multifactorial dimension a cross-sectional survey examining close to 10,000 Danes was undertaken in order to investigate the connection between lifestyle, quality of life and health status by way of a questionnaire based survey. The questionnaire was mailed in February 1993 to 2,460 persons aged between 18-88, randomly selected from the CPR (Danish Central Register) and 7,222 persons from the Copenhagen Perinatal Birth Cohort 1959-61.

A total of 1,501 persons between the ages 18-88 years and 4,626 persons between the ages 31-33 years returned the questionnaire (response rates 61.0% and 64.1% respectively). The results showed that health had a stronger correlation to quality of life ($r=0.5$, $p<0.0001$), than it had to lifestyle ($r=0.2$, $p<0.0001$).

It was concluded that preventable diseases could be more effectively handled through a concentrated effort to improve quality of life rather than through an approach that focus solely on the factors that are traditionally seen to reflect an unhealthy life style.

Collaborations across borders

The project has been developed during several phases. The first phase, 1980-1990, was about mapping the medical systems of the pre-modern cultures of the world, understanding their philosophies and practices and merging this knowledge with western biomedicine. A huge task seemingly successfully accomplished in the Quality of Life (QOL) theories, and the QOL philosophy, and the most recent theories of existence, explaining the human nature, and especially the hidden resources of man, their nature, their location in human existence and the way to approach them through human consciousness.

Søren Ventegodt visited several countries around the globe in the late 1980s and analysed about 10 pre-modern medical systems and a dozen of shamans, shangomas and spiritual

leaders noticing most surprisingly similarities, allowing him together with about 20 colleagues at the QOL Study Group at the University of Copenhagen, to model the connection between QOL and health. This model was later further developed and represented in the integrative QOL theories and a number of publications. Based on this philosophical breakthrough the Quality of Life Research Center was established at the University hospital. Here a broad cooperation took place with many interested physicians and nurses from the hospital.

A QOL conference in 1993 with more than 100 scientific participants discussed the connection between QOL and the development of disease and its prevention. Four physicians collaborated on the QOL population survey 1993. For the next 10 years the difficult task of integrating bio-medicine and the traditional medicine went on and Søren Ventegodt again visited several centers and scientists at the Universities of New York, Berkeley, Stanford and other institutions. He also met people like David Spiegel, Dean Ornish, Louise Hay, Dalai Lama and many other leading persons in the field of holistic medicine and spirituality.

Around the year 2000 an international scientific network started to take form with an intense collaboration with the National Institute of Child Health and Human Development (NICHD) in Israel, which has now developed the concept of “Holistic Medicine”. We believe that the trained physician today has three medical toolboxes: the manual medicine (traditional), the bio-medicine (with drugs and pharmacology) and the consciousness-based medicine (scientific, holistic medicine). What is extremely interesting is that most diseases can be alleviated with all three sets of medical tools, but only the bio-medical toolset is highly expensive. The physician, using his hands and his consciousness to improve the health of the patient by mobilising hidden resources in the patient can use his skills in any cultural setting, rich or poor.

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About the National Institute of Child Health and Human Development in Israel

The National Institute of Child Health and Human Development (NICHD) in Israel was established in 1998 as a virtual institute under the auspices of the Medical Director, Ministry of Social Affairs and Social Services in order to function as the research arm for the Office of the Medical Director. In 1998 the National Council for Child Health and Pediatrics, Ministry of Health and in 1999 the Director General and Deputy Director General of the Ministry of Health endorsed the establishment of the NICHD. In 2011 the NICHD became affiliated with the Division of Pediatrics, Hadassah Hebrew University Medical Center, Mt Scopus Campus in Jerusalem.

Mission

The mission of a National Institute for Child Health and Human Development in Israel is to provide an academic focal point for the scholarly interdisciplinary study of child life, health, public health, welfare, disability, rehabilitation, intellectual disability and related aspects of human development. This mission includes research, teaching, clinical work, information and public service activities in the field of child health and human development.

Service and academic activities

Over the years many activities became focused in the south of Israel due to collaboration with various professionals at the Faculty of Health Sciences (FOHS) at the Ben Gurion University of the Negev (BGU). Since 2000 an affiliation with the Zusman Child Development Center at the Pediatric Division of Soroka University Medical Center has resulted in collaboration around the establishment of the Down Syndrome Clinic at that center. In 2002 a full course on “Disability” was established at the Recanati School for Allied Professions in the

Community, FOHS, BGU and in 2005 collaboration was started with the Primary Care Unit of the faculty and disability became part of the master of public health course on “Children and society”. In the academic year 2005-2006 a one semester course on “Aging with disability” was started as part of the master of science program in gerontology in our collaboration with the Center for Multidisciplinary Research in Aging. In 2010 collaborations with the Division of Pediatrics, Hadassah Medical Center, Hebrew University, Jerusalem, Israel.

Research activities

The affiliated staff have over the years published work from projects and research activities in this national and international collaboration. In the year 2000 the International Journal of Adolescent Medicine and Health and in 2005 the International Journal on Disability and Human development of De Gruyter Publishing House (Berlin and New York), in the year 2003 the TSW-Child Health and Human Development and in 2006 the TSW-Holistic Health and Medicine of the Scientific World Journal (New York and Kirkkonummi, Finland), all peer-reviewed international journals were affiliated with the National Institute of Child Health and Human Development. From 2008 also the International Journal of Child Health and Human Development (Nova Science, New York), the International Journal of Child and Adolescent Health (Nova Science) and the Journal of Pain Management (Nova Science) affiliated and from 2009 the International Public Health Journal (Nova Science) and Journal of Alternative Medicine Research (Nova Science).

National collaborations

Nationally the NICHD works in collaboration with the Faculty of Health Sciences, Ben Gurion University of the Negev; Department of Physical Therapy, Sackler School of Medicine, Tel Aviv University; Autism Center, Assaf HaRofeh Medical Center; National Rett and PKU Centers at Chaim Sheba Medical Center, Tel HaShomer; Department of Physiotherapy, Haifa University; Department of Education, Bar Ilan University, Ramat Gan, Faculty of Social Sciences and Health Sciences; College of Judea and Samaria in Ariel and in 2011 affiliation with Center for Pediatric Chronic Diseases and Center for Down Syndrome, Department of Pediatrics, Hadassah-Hebrew University Medical Center, Mount Scopus Campus, Jerusalem.

International collaborations

Internationally with the Department of Disability and Human Development, College of Applied Health Sciences, University of Illinois at Chicago; Strong Center for Developmental Disabilities, Golisano Children's Hospital at Strong, University of Rochester School of Medicine and Dentistry, New York; Centre on Intellectual Disabilities, University of Albany,

New York; Centre for Chronic Disease Prevention and Control, Health Canada, Ottawa; Chandler Medical Center and Children's Hospital, Kentucky Children's Hospital, Section of Adolescent Medicine, University of Kentucky, Lexington; Chronic Disease Prevention and Control Research Center, Baylor College of Medicine, Houston, Texas; Division of Neuroscience, Department of Psychiatry, Columbia University, New York; Institute for the Study of Disadvantage and Disability, Atlanta; Center for Autism and Related Disorders, Department Psychiatry, Children's Hospital Boston, Boston; Department of Paediatrics, Child Health and Adolescent Medicine, Children's Hospital at Westmead, Westmead, Australia; International Centre for the Study of Occupational and Mental Health, Düsseldorf, Germany; Centre for Advanced Studies in Nursing, Department of General Practice and Primary Care, University of Aberdeen, Aberdeen, United Kingdom; Quality of Life Research Center, Copenhagen, Denmark; Nordic School of Public Health, Gottenburg, Sweden, Scandinavian Institute of Quality of Working Life, Oslo, Norway; Centre for Quality of Life of the Hong Kong Institute of Asia-Pacific Studies and School of Social Work, Chinese University, Hong Kong.

Targets

Our focus is on research, international collaborations, clinical work, teaching and policy in health, disability and human development and to establish the NICHD as a permanent institute at one of the residential care centers for persons with intellectual disability in Israel in order to conduct model research and together with the four university schools of public health/medicine in Israel establish a national master and doctoral program in disability and human development at the institute to secure the next generation of professionals working in this often non-prestigious/low-status field of work.

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Section 3. Index

Index

#

20th century, xv, 23, 26, 175

A

Abraham, 131, 139, 155, 182, 252
abuse, 80, 89, 95, 100, 103, 124, 127, 138, 139, 150, 159, 160, 166, 167, 173, 181, 184, 188, 191, 192, 193, 195, 223, 225, 226, 227, 228, 237, 238, 246, 251, 257, 258, 259, 261, 269, 280, 284, 287, 288, 291, 300, 305
access, 201
accommodation, 25, 150, 166
acne, 199
acupuncture, 95
adaptation, 179, 184
adenocarcinoma, 200
adhesions, 107
adjustment, 179
adolescent development, 123
adolescents, 123, 124, 125, 126, 160
adulthood, 309
adults, 10, 138, 228
advancement, 31
adverse effects, xvi, 71, 99, 100, 102, 103, 104, 105, 215
adverse event, 204
advocacy, 305
aetiology, 104
age, 41, 44, 45, 47, 48, 49, 50, 51, 102, 123, 124, 131, 134, 147, 176, 177, 178, 236, 246, 249, 250, 258, 262, 266, 271, 292
aggression, 134
AIDS, 141
alcohol abuse, 57
alcoholics, 236

alcoholism, 64, 240, 254
alienation, 172
allergy, 141
alternative medicine, 100
amenorrhea, 187, 200
amniotic fluid, 264
anatomy, 28, 45
anger, 13, 88, 136, 175, 227, 281, 283
anorexia, 129, 130, 131, 132, 134, 135, 139
anorexia nervosa, 129, 130, 131, 134, 135, 139
anorgasmia, 67, 70, 71, 74, 75, 76, 99, 100, 104, 105, 106, 108, 109, 110, 138, 181, 188, 195, 205, 215
anoxia, 200
antibiotic, 32, 194
anti-cancer, 194
antidepressant, 104, 124, 125, 238
antidepressant medication, 124
anus, 29, 81, 133, 135, 138, 188, 192, 195, 250, 259
anxiety, 8, 125, 136, 211, 238
appetite, 130, 246, 277
appointments, 93, 281
arousal, 28, 29, 31, 67, 70, 107, 108, 112, 264
arthritis, 59
ascorbic acid, 112
Asia, 9, 317
assault, 56, 57, 58, 59, 61, 62, 184, 232, 233, 235, 250, 267
assessment, 29, 43, 71, 105, 125, 236
asthma, 141
atheists, 59
atherosclerosis, 39
atmosphere, 7, 14, 28, 226
atrocities, 235
attitudes, 7, 39, 130, 139, 153, 193, 199, 202, 259, 297, 311
Austria, 77, 205, 305
authorities, 57, 59
authority, 123

autism, 127, 133
 autoimmune disease, 141
 autonomy, 174
 aversion, 67, 70, 131, 187, 188, 200
 awareness, 25, 28, 54, 107, 152, 160, 170, 175, 221,
 233, 234, 245, 251, 259, 287

B

bacteria, 151, 166
 ban, 259
 banks, 310
 base, 102
 basic needs, 38
 behavior therapy, 239, 288, 300
 beneficial effect, 39, 117
 benefits, 93, 104, 213
 benign, 200
 bias, 61, 62
 bible, 169
 binge eating disorder, 129, 130
 biochemistry, 144, 184, 222
 black market, 214
 blame, 60, 62, 193, 233
 bleeding, 57, 59, 87, 249, 268, 277
 blood, 57, 112, 197, 236, 264, 268, 269, 272
 blood circulation, 57
 blood pressure, 112
 body image, 130, 160
 body shape, 200, 201
 bonding, 220
 bone, 101
 boredom, 171
 brain, 59, 143, 144, 150, 155, 166, 183, 222, 240,
 253, 283, 301
 breakdown, 243, 251, 252
 breast cancer, 38, 39, 204
 breathing, 90
 brief reactive psychosis, 203
 Britain, 64
 bronchitis, 57
 brutality, 266
 Buddhism, 21
 Buddhist countries, xv
 bulimia, 129, 130, 131, 132, 135, 139, 200
 bulimia nervosa, 129, 130, 131, 132
 bun, 268
 burn, xvii, 130
 burnout, 111, 141

C

CAM, 99, 100, 101, 102, 104, 190, 192, 195, 204,
 218, 305
 cancer, 26, 33, 58, 64, 136, 142, 161, 188, 189, 190,
 197, 201, 203, 204, 285
 candidiasis, 199
 carbohydrates, 130
 carcinoma, 200
 case study, 82, 213, 291
 catalyst, 202
 catharsis, 174
 causality, 61
 cerebral cortex, 144
 challenges, 61, 65, 234, 240, 245, 254
 chancroid, 199
 chaos, 54, 227
 chemical, 309
 chemotherapy, 190, 200
 Chicago, 33, 316
 chicken, 282
 child abuse, 181
 child development, 76, 127, 140, 155, 182, 220, 240,
 253, 289
 child pornography, 163, 177
 childhood, 11, 13, 24, 26, 56, 59, 61, 63, 69, 75, 87,
 88, 95, 103, 110, 115, 116, 124, 132, 133, 137,
 140, 143, 150, 159, 166, 176, 191, 192, 197, 212,
 214, 215, 217, 218, 220, 221, 223, 232, 238, 243,
 244, 246, 247, 252, 257, 258, 261, 284, 287, 288,
 291, 292, 294, 295, 297, 299, 300, 309
 childhood sexual abuse, 75, 103, 110, 132, 140, 143,
 221, 238, 284, 288, 291, 292, 300
 children, 10, 12, 13, 41, 58, 124, 141, 149, 150, 156,
 165, 177, 178, 196, 212, 213, 216, 231, 234, 248,
 251, 309
 China, xv
 cholesterol, 311
 chronic fatigue, 141
 chronic illness, 64, 125, 240, 254
 chronic irritation, 189
 circulation, 311
 circumcision, 200, 201
 cities, 178
 citizens, 41
 city, 101
 classical methods, xvi
 classroom, 155, 182, 252
 cleaning, 258
 clients, 176, 239, 286, 288, 300
 clinical holistic medicine, xvi, xviii, 99, 102, 104,
 115, 116, 132, 136, 140, 141, 142, 145, 194, 198,
 204, 213, 214, 218, 286

- clinical interventions, xvi
 clinical problems, xvi
 clinical trials, xvi, 189
 close relationships, 125
 closure, 225
 coal, 272, 274, 280
 cocaine, 214
 coding, 298
 coffee, 265
 cognitive therapy, 286
 coherence, 38, 77, 115, 119, 120, 136, 140, 142, 153,
 182, 193, 198, 217, 222, 289, 293, 297, 311
 collaboration, 271, 305, 307, 309, 312, 315, 316
 college students, 159
 colon, 248
 coma, 293
 commercial, 94, 130
 communication, 28, 37, 95, 96, 125, 214
 communism, 59
 community, 41, 51, 55, 58, 147, 173
 compassion, 234
 complexity, 174, 291, 293
 complications, 138
 comprehension, 263
 compression, 29
 computer, 309
 conception, 37, 168, 179
 concordance, 112
 concrete thinking, 123
 conference, 210, 312
 confidentiality, 31, 125
 conflict, 23, 26, 108, 130, 212, 216
 confrontation, 21, 99, 101, 102, 193
 connective tissue, 29
 consciousness, xiii, xv, xvi, 8, 9, 18, 21, 23, 26, 38,
 39, 53, 62, 63, 64, 76, 80, 95, 99, 103, 120, 136,
 140, 141, 143, 144, 149, 151, 155, 156, 161, 165,
 167, 169, 173, 180, 182, 183, 184, 193, 195, 204,
 216, 217, 221, 222, 223, 225, 228, 239, 240, 251,
 253, 258, 260, 261, 278, 284, 285, 288, 289, 292,
 293, 294, 299, 300, 301, 311, 312
 consciousness-based medicine, 8, 64, 76, 120, 140,
 141, 155, 161, 182, 223, 239, 240, 253, 284, 288,
 289, 300, 312
 consensus, 30, 310
 consent, 31, 82, 102, 107, 174, 175, 193, 195, 202,
 247
 constipation, 262
 construction, 55, 142, 222, 225
 consulting, 310
 consumption, 82
 contour, 25
 control group, 38, 39
 controversial, 108, 214, 286
 conversations, 125
 conviction, 191
 cooperation, 312
 copyright, 94
 coronary arteries, 39
 coronary heart disease, 39, 190, 204
 correlation, 43, 44, 47, 50, 53, 55, 56, 311
 correlation coefficient, 43, 47
 cortisol, 112
 cosmetic, 200, 201
 cost, 65, 117, 204, 213, 240, 254
 cotton, 188
 counsel, 75, 120, 140, 147, 161, 182, 252, 289
 cracks, 236
 craving, 173
 creativity, 144, 183, 222
 crises, 10, 104, 195, 260, 293, 297
 criticism, 12, 226, 265
 cultural norms, 41
 culture, xv, 3, 7, 31, 82, 100, 101, 147, 150, 165,
 178, 179, 195, 211, 212, 237, 286, 311
 cure, xiii, xv, xvi, xvii, 17, 24, 26, 30, 33, 64, 68, 71,
 74, 81, 90, 105, 116, 119, 132, 136, 141, 155,
 177, 183, 189, 190, 191, 193, 194, 198, 226, 228,
 233, 240, 254, 284
 cycles, 28, 148, 163, 244
 cycling, 58
 cytomegalovirus, 126

D

- damages, 269
 dance, 265
 danger, 71, 74, 90, 91, 105, 106, 195, 203
 dark power games, 13
 data collection, 92
 debts, 59
 decay, 21, 298
 defecation, 133
 defects, 175, 309
 defence, 227, 280
 defense mechanisms, 112
 deficiencies, 9
 Delta, 83, 85, 86
 denial, 39, 100, 211, 278, 292, 295
 Denmark, 9, 14, 41, 44, 50, 51, 54, 63, 68, 74, 75,
 102, 103, 110, 120, 132, 138, 143, 154, 174, 182,
 184, 195, 204, 214, 252, 305, 309, 310, 312, 317
 Department of Education, 316
 dependent variable, 55
 depression, 8, 42, 104, 198

depth, 7, 8, 77, 184, 196, 199, 205, 231, 238, 257, 287

dermis, 236

despair, xvi, 137, 215, 216

destiny, 218

destruction, 135, 291, 298, 299

detachment, 283

detectable, 99

diet, 311

dieting, 130

dignity, 9

direct observation, 103

disability, 42, 59, 305, 315, 316, 317

disappointment, 24

disaster, 192

discharges, 106

discomfort, 27, 42, 45, 47, 48, 49, 50, 79, 81, 82, 83, 87, 89, 91, 107, 152, 170, 188, 189, 194, 199, 200, 280

discrete variable, 43

discrimination, 180

discs, 248

diseases, 53, 56, 80, 111, 138, 142, 160, 187, 196, 199, 200, 215, 310, 311, 312

disgust, xvi, 88, 167, 175, 177, 181, 188, 197

dislocation, 129

disorder, 67, 70, 129, 130, 131, 132, 134, 135, 136, 137, 138, 139, 188, 190, 191, 192, 197, 198, 199, 202, 239, 288, 300

dispersion, 129

displacement, 133

dissatisfaction, 59

dissociation, 138, 233

distress, 13, 30, 126

diversity, 102

doctors, 28, 191, 195, 212, 213, 214, 220

dominance, 228

dosage, 283

draft, 237

drawing, 235, 258, 262, 283

dream, 177, 210, 229, 260, 266, 273, 276, 277, 279, 283

drug abuse, 124, 126

drugs, 32, 57, 130, 136, 138, 150, 155, 166, 183, 190, 194, 197, 251, 270, 312

DSM-IV-TR, 188

dyspareunia, xviii, 23, 28, 29, 31, 32, 33, 34, 67, 69, 70, 95, 131, 187, 188, 197

dysplasia, 188, 189, 190, 197, 200

E

eating disorders, 17, 124, 127, 129, 130, 131, 132, 134, 135, 136, 137, 138, 139, 200

eating disturbances, 124

economic status, 309

economics, 82

ecstasy, xvii, 34, 156, 163, 166, 168, 181, 183

eczema, 141, 199

education, 9, 25, 32, 43, 68, 123, 148, 155, 164, 182, 193, 252

educational experience, 284

egg, 10, 168, 179, 180

ejaculation, xviii, 24, 31, 34, 41, 42, 45, 48, 49, 50, 131, 151, 163, 167, 168, 181

elective abortion, 124

e-mail, 281

emergency, 124

emotion, 12, 60, 154, 170, 298

emotional intelligence, 142

emotional problems, 21, 24, 26, 30, 31, 33, 69, 80, 147, 175, 181, 190, 246, 247

employees, 310

employment, 43, 59

empowerment, 160

encouragement, 123, 125

endangered, 299

energy, 3, 13, 17, 24, 26, 37, 38, 39, 81, 89, 101, 102, 106, 129, 133, 134, 135, 136, 139, 144, 164, 166, 168, 172, 175, 176, 179, 180, 183, 190, 202, 209, 210, 211, 212, 215, 217, 219, 220, 222, 226, 227, 231, 238, 247, 274, 275

England, 147

environment, 125, 133, 191, 251, 287

equality, 278

erectile dysfunction, 23, 24, 26, 41

erectile impotency, xvi, 31, 33

erythema multiforme, 199

ethical implications, 30

ethical standards, 71, 90, 105, 232

ethics, 31, 63, 80, 81, 109, 110, 124, 153, 154, 170, 171, 173, 187, 194, 202, 205, 209, 212, 249, 251, 259, 284, 285, 286

etiology, 32, 228

Europe, xv, 28, 81, 101, 125, 127, 192

evidence, 28, 32, 65, 130, 180, 189, 223, 240, 254

evil, 24, 76, 89, 134, 140, 150, 155, 166, 177, 178, 181, 182, 191, 240, 243, 244, 253, 259, 265, 270, 274, 277, 278, 280, 287, 289, 292, 293, 301

evolution, 144, 151, 166, 184, 222, 229

examinations, 29, 188

exercise, xvii, 25, 27, 33, 76, 96, 106, 113, 130, 142, 237, 248, 311

existential healing, xvii, 37, 61, 62, 67, 70, 74, 75,
99, 101, 119, 174, 198, 211, 216, 217, 234, 245,
260
expertise, 307
exploitation, 193, 218, 258, 286
exposure, 239, 288, 300
extrovert, 166, 168

F

family members, 280
family physician, 10, 39, 232
family therapy, 232, 239, 258, 288, 300
fantasy, 178, 210, 226, 228
fasting, 57
fat, 130, 268
fear, 28, 30, 59, 89, 90, 125, 147, 160, 177, 188, 201,
229, 233, 250, 260, 261, 271, 274
feelings, xv, xvi, 7, 27, 30, 50, 60, 62, 69, 79, 80, 88,
89, 99, 100, 101, 107, 108, 110, 119, 130, 132,
149, 151, 152, 153, 159, 160, 164, 165, 166, 167,
169, 170, 171, 172, 175, 181, 187, 189, 190, 191,
193, 194, 201, 203, 210, 212, 216, 225, 227, 231,
233, 235, 236, 238, 247, 249, 250, 257, 259, 261,
262, 280, 283, 286, 292, 293, 297, 299
female disorders, xvi
female dyspareunia, 23, 33
female partner, xvi, 24, 32, 33
fever, 263, 283
fibromyalgia, 141
fidelity, 12
films, 101
financial, 59, 218
Finland, 316
fistulas, 231
fluid, 106
food, 58, 130, 150, 155, 166, 183, 236, 265, 268, 271
force, 134, 179, 191
formation, 77, 184, 205
formula, 92, 271
free will, 37
freedom, 67, 149, 151, 165, 167, 169, 229, 292
Freud, xv, xvii, xviii, 3, 23, 26, 31, 33, 35, 68, 76,
109, 111, 132, 133, 137, 138, 140, 173, 174, 176,
177, 179, 184, 191, 192, 198, 199, 203, 209, 210,
211, 212, 213, 214, 217, 218, 219, 220, 221, 225,
226, 227, 228, 229, 293
Freud, Sigmund, xv, xviii, 26, 33, 173, 203, 220, 221
friction, 25, 274
friendship, 12, 236, 277, 281, 307
funds, 309, 310

G

garbage, 276
general practitioner, 50, 160, 201, 243
genes, 144, 151, 166, 177, 184, 222
genetic defect, 310
genetic factors, 37
genital warts, 199
genitals, xvi, 26, 33, 68, 69, 81, 89, 99, 100, 101,
102, 106, 107, 108, 109, 110, 129, 133, 135, 137,
138, 151, 159, 166, 176, 181, 187, 188, 189, 191,
192, 193, 194, 197, 201, 202, 211, 215, 220, 251,
286
Germany, 204, 317
gerontology, 316
Gestalt, 95
gifted, 202
God, 169, 198
grants, 309
Greece, xv, 81, 138
group therapy, 64, 99, 101, 102, 103, 232, 239, 240,
243, 253, 258, 288, 300
group treatment, 95
growth, 28, 57, 59, 181, 184, 187, 197
guessing, 228
guidance, 69, 70, 148, 164, 234, 244
guidelines, 71, 105, 125
guilt, 87, 89, 99, 100, 101, 110, 130, 160, 172, 175,
181, 193, 194, 210, 227, 233, 250, 264
gynecologist, 309

H

hair, 264
happiness, xvi, 44, 53, 61, 143, 149, 155, 164, 165,
169, 183, 240, 249, 253, 299, 301, 311
harassment, 56, 61, 63, 134
hardness, 23, 31
harmony, 8
headache, 8, 174, 261
healing, xv, 7, 8, 14, 18, 21, 33, 61, 62, 64, 65, 70,
71, 75, 80, 81, 89, 90, 95, 100, 103, 105, 111,
115, 116, 119, 120, 136, 138, 141, 144, 152, 153,
154, 160, 161, 170, 171, 172, 173, 175, 178, 189,
191, 193, 194, 195, 197, 198, 199, 201, 202, 203,
204, 206, 209, 211, 214, 215, 216, 217, 218, 219,
220, 221, 225, 226, 231, 234, 238, 239, 240, 243,
244, 245, 246, 251, 252, 253, 257, 258, 259, 260,
266, 267, 270, 284, 285, 287, 288, 289, 291, 292,
297, 298, 299, 300, 301
health, xvi, 28, 32, 37, 38, 39, 43, 50, 53, 56, 59, 60,
61, 62, 63, 67, 68, 70, 71, 72, 74, 76, 77, 81, 90,

- 93, 102, 105, 109, 111, 115, 116, 120, 123, 125, 127, 139, 140, 141, 142, 143, 144, 149, 151, 153, 155, 165, 167, 171, 173, 174, 182, 183, 184, 187, 189, 190, 192, 197, 198, 201, 202, 204, 205, 217, 221, 222, 223, 232, 240, 254, 270, 289, 291, 293, 297, 299, 305, 309, 311, 312, 315, 317
- health care, 123, 125, 173
- health practitioners, 174
- health problems, 60, 68, 102, 116, 187, 190, 197, 201
- health services, 93
- health status, 56, 60, 311
- heart failure, 214
- heart rate, 112, 239, 288, 300
- height, 246
- helplessness, 136, 175, 177, 181, 293
- hemisphere, 129
- hepatitis, 126
- heterosexuality, 176
- high fat, 311
- Hippocratic tradition, xv, 108, 213
- Hippocratic tradition of sexology, xv
- history, 37, 106, 109, 124, 126, 132, 138, 145, 159, 160, 180, 187, 192, 195, 201, 212, 239, 247, 287, 288, 300
- HIV, 124, 126, 141
- HIV/AIDS, 126
- hives, 264
- holistic medicine, xiii, xviii, 3, 17, 21, 34, 35, 37, 61, 63, 64, 65, 68, 75, 76, 77, 80, 94, 95, 96, 106, 110, 111, 112, 119, 120, 132, 136, 137, 138, 139, 140, 141, 142, 143, 144, 155, 156, 160, 161, 164, 168, 172, 182, 183, 184, 189, 191, 198, 199, 203, 204, 205, 209, 211, 213, 214, 215, 216, 219, 220, 221, 222, 229, 232, 234, 236, 238, 239, 240, 243, 245, 246, 251, 252, 253, 254, 260, 263, 266, 284, 285, 288, 289, 300, 301, 305, 312
- holistic sexological therapy, xv, 67, 69, 136, 152, 169, 170, 175, 177, 214
- holistic tradition, xvi
- homes, 124
- homework, 201, 236
- homicide, 124
- homosexuality, 163, 176
- homosexuals, 44
- honesty, 8, 174, 212
- Hong Kong, 317
- hopelessness, xvi, 136, 177, 233, 238
- host, 125
- house, 316
- human, xv, xvi, 9, 18, 23, 26, 30, 31, 33, 37, 39, 43, 64, 65, 76, 77, 102, 108, 120, 126, 130, 134, 139, 140, 142, 143, 144, 148, 149, 150, 155, 161, 163, 164, 165, 169, 172, 179, 181, 182, 183, 196, 198, 199, 202, 203, 210, 212, 214, 216, 217, 218, 231, 233, 234, 239, 240, 243, 244, 251, 252, 253, 254, 283, 285, 289, 292, 294, 297, 298, 301, 305, 311, 315, 317
- human body, 196
- human brain, 144
- human coitus, xv
- human development, 139, 196, 305, 315, 317
- human existence, 43, 76, 140, 148, 155, 164, 182, 240, 253, 285, 289, 311
- human nature, 26, 43, 130, 149, 165, 179, 311
- human values, 285
- husband, 9, 10, 12, 71, 105, 234, 258
- hypothesis, xviii, 34, 54, 68, 69, 74, 80, 129, 139, 311
- hysteria, xv, xvii, 81, 106, 109, 191, 211, 221, 228



- identity, 260
- ideology, 112
- illusions, 21
- image, 155, 182, 270, 271, 281, 282
- imbalances, 11, 189, 196
- immune function, 199
- immune system, 160, 190
- impetigo, 199
- impotence, 163, 175
- imprisonment, 226, 269
- improvements, 87
- impulses, 216
- incidence, 41, 232, 258
- income, 43, 55
- independence, 283
- India, xv, 175
- individuals, 169, 235
- induction, 71, 76, 95, 100, 103, 105, 111, 116, 117, 144, 161, 204, 223
- industrial revolution, 81
- industry, xix, 23, 33
- infancy, 26, 63, 65
- infection, 32, 69, 160, 187, 199, 200, 310
- infertility, xvi, 64, 75, 81, 95, 110, 140, 156, 161, 182, 205, 239, 253, 289, 301
- inflammation, 187, 190, 197, 200
- inflammatory disease, 124
- inhibition, 154, 170
- initiation, 99, 131
- injuries, 235
- insane, 259, 260, 280, 297
- insanity, 244, 251
- insecurity, xvi, 284

institutions, 287, 310, 312
 integration, 59, 60, 77, 79, 99, 101, 178, 184, 195,
 205, 209, 226, 243, 252, 258, 299
 integrity, 7, 29, 61, 63, 195
 intelligence, 10, 149, 165, 284, 285
 intentionality, 172
 intercourse, xvi, 8, 25, 26, 27, 29, 32, 33, 42, 45, 47,
 48, 49, 50, 56, 59, 61, 62, 87, 102, 107, 112, 116,
 131, 151, 167, 198, 226, 228, 264, 265
 internalised, 180
 interstitial cystitis, xviii, 34
 intervention, xiii, 26, 41, 64, 70, 99, 100, 101, 102,
 104, 107, 152, 170, 187, 200, 203, 238, 240, 253,
 286, 288, 300
 intimacy, 7, 13, 71, 82, 90, 105, 137, 154, 171, 172,
 180, 193, 196, 204, 211, 216, 238, 245, 246, 247,
 251, 259, 284, 286
 introitus, 190, 196, 197, 249, 257
 introvert, 166
 investment, 210
 irritant eczema, 199
 isolation, 130
 Israel, 155, 182, 204, 305, 309, 312, 315, 317
 issues, 32, 82, 115, 116, 117, 118, 119, 123, 124,
 125, 126, 138, 148, 152, 159, 164, 170, 172, 174,
 187, 189, 190, 194, 197, 200, 203, 213, 214, 215,
 216, 218, 226, 243, 244, 249, 292, 293

J

Japan, xv
 job training, 57
 justification, 212

K

kidney, 129, 138, 188
 kill, 178, 235, 250, 273, 278, 279, 280, 283, 294,
 295, 296
 Kinsey, xv, xvii, 44
 knees, 273

L

larva, 260
 larvae, 298
 laws, 79, 137, 175, 252
 laws and regulations, 252
 lead, 23, 26, 50, 61, 63, 102, 126, 136, 138, 149,
 165, 179, 191, 211, 214, 228, 260, 287, 310
 learning, 61, 110, 125, 176, 231, 233, 238, 287, 298
 legs, 209, 248, 263, 268, 272, 273, 274

leisure, 43, 46, 236
 lending, 272
 lentigo, 200
 lesions, 200, 231
 levator, 68
 liberation, 89, 108
 libido, 131, 214
 lice, 199
 lichen, 187, 188, 199, 200, 202
 lichen planus, 187, 199, 200, 202
 life changes, 184
 lifestyle changes, 39, 204, 310
 light, 27, 30, 32, 132, 152, 163, 173, 174, 177, 180,
 188, 280
 Likert scale, 43, 54, 70, 72, 79, 82, 87
 linguistics, 160
 locomotor, 80, 111, 141
 locus, 197
 loneliness, 10, 57
 loss of appetite, 10, 130
 love, xv, xvi, xvii, xviii, 7, 8, 9, 10, 11, 12, 13, 14,
 18, 31, 35, 80, 89, 101, 111, 112, 117, 134, 139,
 149, 150, 152, 153, 164, 165, 166, 169, 170, 172,
 173, 174, 175, 177, 178, 180, 181, 184, 192, 201,
 210, 215, 216, 217, 219, 220, 221, 229, 234, 236,
 238, 243, 244, 245, 246, 248, 249, 251, 257, 258,
 262, 263, 264, 270, 277, 285, 287, 292, 293, 297,
 299
 lower lip, 250
 lupus, 59
 lying, 11, 247, 261, 264, 267, 268, 270, 272, 278,
 279, 280, 283

M

magazines, 271
 magnitude, 44
 major depression, 103, 104
 majority, 3, 50, 90, 172, 203
 maltreatment, 247, 291
 man, xv, 7, 24, 26, 27, 31, 32, 76, 140, 144, 151,
 152, 154, 155, 167, 168, 169, 171, 176, 177, 180,
 181, 182, 184, 191, 193, 196, 198, 210, 211, 212,
 222, 227, 231, 235, 237, 240, 243, 244, 250, 253,
 260, 264, 265, 267, 270, 277, 289, 292, 301, 311
 management, xviii, 34, 35, 76, 112, 142, 203, 310
 manipulation, 100, 106, 202
 manual procedures, xv
 manual sexological therapy, xvi, 31, 74, 104, 105,
 194
 mapping, 26, 28, 153, 170, 311
 marital life, 71, 105, 107, 108
 marriage, 58, 210, 213, 218

- married couples, 41
 masculinity, 192
 mass, 11
 matrix, 180
 matter, 125, 144, 174, 194, 221, 263, 274
 measurement, 42, 43, 310
 media, 195, 226
 medical, xv, xvi, 23, 27, 32, 37, 41, 57, 58, 64, 68, 69, 74, 80, 81, 83, 91, 92, 95, 100, 105, 106, 108, 110, 130, 135, 141, 147, 152, 153, 154, 156, 160, 161, 168, 170, 171, 172, 174, 184, 187, 189, 191, 193, 194, 195, 196, 197, 200, 201, 204, 211, 213, 215, 233, 238, 239, 243, 245, 251, 252, 257, 259, 269, 271, 284, 286, 288, 289, 291, 292, 293, 299, 301, 305, 309, 311, 312
 medical reason, xvi
 medical science, xv, 23, 64, 81, 95, 141, 156, 161, 184, 204, 239, 289, 301
 medication, 152, 214, 238, 284
 medicine, xiii, xvii, 3, 8, 17, 27, 33, 34, 39, 62, 64, 65, 76, 77, 79, 95, 99, 100, 102, 111, 112, 120, 124, 125, 126, 127, 132, 136, 140, 141, 142, 143, 155, 156, 161, 173, 182, 184, 187, 189, 190, 191, 195, 198, 199, 202, 203, 204, 205, 209, 211, 219, 220, 221, 223, 231, 239, 240, 247, 252, 253, 254, 258, 263, 284, 285, 288, 289, 300, 305, 307, 312, 317
 melanoma, 200
 melody, 297
 melt, 163, 177
 melting, 11, 168
 memory, 75, 80, 90, 140, 159, 180, 205, 223, 225, 226, 227, 228, 229
 menopause, 150, 166
 mental disorder, 3, 17, 21, 111, 120, 142, 191, 198, 253, 300
 mental health, 26, 38, 59, 67, 68, 69, 70, 74, 77, 79, 85, 87, 88, 91, 93, 107, 116, 117, 119, 138, 243, 244, 292, 299
 mental illness, xv, 76, 109, 111, 130, 144, 204, 211, 222, 287, 298
 mental processes, 234
 mental state, 188, 292
 messages, 281
 meta-analysis, 120, 223
 metamorphosis, 144, 184, 202, 216, 222, 293, 297, 298
 metaphor, 260, 297, 298
 metastatic cancer, 200, 203
 methodology, 95, 120, 141, 183, 205, 221
 military, 58, 59
 mind-body, 190, 192, 204, 233, 307
 Ministry of Education, 305
 minors, 201
 mission, 7, 21, 37, 38, 39, 61, 64, 69, 76, 77, 120, 127, 134, 140, 141, 142, 148, 149, 155, 161, 164, 175, 182, 220, 223, 228, 234, 239, 240, 243, 244, 245, 252, 253, 260, 289, 292, 300, 301, 305, 315
 misunderstanding, 213
 models, 130, 148, 149, 164, 165, 244
 modern society, 138
 modules, 144
 molecules, 169
 monks, xvi
 morbidity, 30, 124, 125, 126
 morphine, 150, 166
 morphogenesis, 144, 180, 183, 222
 mortality, 124, 125, 126
 motivation, 147, 150, 165, 169, 179, 189, 243, 244, 292
 mucosa, 188, 190, 197, 200
 multidimensional, 32
 multiple factors, 125
 murder, 163, 178
 muscle contraction, 106
 muscles, xvii, 24, 25, 33, 68, 76, 100, 101, 113, 133, 142, 188
 music, 58, 144, 265, 269
 mutual respect, 9

N

- naming, 193
 narcotics, 61, 63
 Native Americans, 18
 natural appearance, 89
 nausea, 95, 270, 274, 276, 279
 negative attitudes, 11, 80, 202, 234, 245
 negative effects, 91
 negative emotions, 159, 177, 197, 200, 201, 202, 259
 negative experiences, 62
 neglect, 149, 165, 178, 195, 227, 285
 negotiation, 135
 nerve, 107
 Netherlands, 310
 neurobiology, 95, 223
 neutral, 10, 43, 174, 227
 next generation, 317
 Nobel Prize, 305
 normal development, 126
 Norway, 317
 nudity, 108, 282
 null, 43
 null hypothesis, 43
 nuns, xvi
 nurses, 108, 251, 258, 312

O

objective criteria, 104
 occlusion, xviii, 34
 oedema, 29, 199
 Oedipus complex, 3, 69, 177, 195, 225, 226, 228, 229
 offenders, 269
 old age, 60, 64
 openness, 58, 82, 258
 optimism, 213
 organism, 38, 150, 166, 169, 175, 179, 180
 organs, 25, 29, 42, 54, 69, 80, 111, 129, 131, 133, 135, 136, 137, 138, 139, 141, 152, 159, 170, 172, 175, 187, 189, 190, 191, 192, 197, 199, 203, 237, 243, 244, 249, 292
 orgasm, xvi, xvii, xviii, 23, 26, 30, 31, 33, 34, 41, 42, 45, 47, 48, 49, 50, 76, 79, 83, 87, 90, 94, 95, 99, 100, 101, 102, 103, 104, 106, 108, 109, 110, 112, 131, 132, 135, 140, 143, 151, 153, 155, 163, 166, 167, 168, 170, 175, 176, 180, 181, 182, 195, 196, 197, 198, 205, 215, 221, 248, 264, 274, 279
 oriental traditions, xvi
 outpatient, 41, 51, 139
 ovaries, 188
 overweight, 12, 136, 236

P

pain management, 204
 palliative, 201
 palpation, 27, 29
 parallel, 134, 136, 137, 139
 paranoia, 250
 parenting, 71, 90, 99, 101, 105, 108, 170, 172, 211, 221, 245
 parents, 57, 110, 124, 125, 130, 133, 147, 149, 165, 179, 191, 201, 212, 213, 215, 216, 227, 229, 236, 278
 participants, 29, 33, 70, 71, 72, 82, 103, 104, 105, 249, 260, 263, 265, 312
 patents, 70
 pathogenesis, 257
 pathology, 27, 125, 139, 177
 peace, 248, 280
 peak experience, 59
 pediatrician, 309
 peer influence, 123
 peer review, 160
 pelvic floor, xvi, xviii, 24, 27, 29, 32, 34, 68, 75, 76, 81, 87, 91, 96, 101, 143, 191, 206
 pelvic floor physical therapy, xvi, xviii, 34

pelvic inflammatory disease, 124
 pelvic physiotherapy, xvi, 29
 pelvis, 12, 29, 79, 80, 81, 88, 108, 135, 151, 152, 166, 170, 188, 191, 194, 196, 203, 237, 243, 244, 266, 292
 pemphigus, 199
 penis, 24, 81, 175, 196, 197, 264, 268, 274
 perineum, 29
 permission, 94, 244, 246
 perpetrators, 250
 personal development, xvii, 7, 9, 12, 59, 88, 119, 172, 191, 201, 236, 284
 personal history, 136, 172, 189, 192, 236, 238, 292
 personal problems, 89
 personal relations, 201, 227
 personal relationship, 227
 personal responsibility, 310
 personality, 7, 13, 17, 74, 90, 105, 130, 134, 136, 149, 165, 179, 198, 199, 216, 217, 281
 personality disorder, 17, 141, 198, 199
 personality type, 130
 pharmaceutical, xix, 23, 33, 189, 200, 204
 pharmacological treatment, 199
 pharmacology, 312
 Philadelphia, xvii, 33, 34, 77, 112, 205, 252
 physical abuse, 65, 139
 physical health, xvi, 38, 59, 60, 62, 67, 70, 74, 85, 88, 93, 117, 141, 142, 197, 222
 physical therapy, xvi, xviii, 28, 29, 30, 34, 68, 75, 91, 95, 96, 191, 206
 physicians, xv, xvii, 3, 23, 50, 68, 74, 79, 82, 91, 105, 106, 107, 108, 109, 129, 132, 134, 137, 152, 154, 160, 172, 173, 181, 187, 191, 192, 195, 202, 214, 218, 251, 285, 310, 312
 physiological description, xv
 physiology, 25, 28
 pigmentation, 200
 pilot study, 64, 75, 79, 91, 131, 140, 141, 240, 254
 placebo, 32
 planets, 268, 276
 playing, 237, 272, 293
 pleasure, 25, 26, 28, 31, 33, 99, 100, 101, 108, 112, 133, 134, 135, 136, 140, 149, 150, 151, 163, 164, 166, 167, 168, 169, 175, 177, 180, 181, 196, 197, 200, 201, 202, 216, 219, 231, 248, 283, 285
 PMS, 187, 200
 pneumonia, 284
 polarity, 147, 150, 151, 152, 154, 165, 167, 168, 170, 179, 180
 police, 234, 258
 policy, 317
 political affiliations, 59
 political party, 58

political problems, xvi
 population, 14, 41, 42, 43, 44, 45, 50, 51, 53, 54,
 115, 124, 126, 176, 181, 184, 188, 231, 232, 238,
 312
 positive attitudes, 110
 posttraumatic stress, 239, 288, 300
 pregnancy, 63, 65, 95, 124, 309
 prepuce, 107, 188
 prestige, 150, 166
 prevention, 33, 53, 82, 305, 312
 preventive approach, 124
 principles, 17, 95, 126, 232, 240, 253, 259, 288, 300
 probe, 54
 professionalism, 31
 professionals, 31, 309, 315, 317
 prognosis, 76, 112, 142, 203
 project, 9, 26, 30, 69, 102, 137, 139, 169, 173, 181,
 236, 251, 259, 307, 309, 310, 311
 prolactin, 112
 prolapse, 29
 prophylactic, 39
 prosperity, 9
 protection, 31, 150, 166
 pruritus, 187, 196, 200
 psoriasis, 199
 psychiatric disorders, 120, 223
 psychiatric illness, 218
 psychiatric patients, 260
 psychiatrist, 124, 250, 270
 psychiatry, 3, 21, 71, 90, 105, 126, 135, 138, 243,
 244, 246, 286, 289, 299, 305
 psychic energy, 179
 psychoanalysis, xvi, xvii, 35, 76, 111, 140, 174, 179,
 184, 199, 209, 210, 211, 212, 213, 214, 215, 218,
 219, 220, 225, 226, 229
 psychoanalytic tradition, xv
 psychobiology, 95, 205, 223
 psychodynamic aspects, xvi
 psychodynamic perspective, 100, 101, 212
 psychological problems, 83, 88, 89, 201
 psychological states, 38
 psychologist, 124, 132, 235
 psychology, 21, 45, 71, 77, 90, 105, 143, 156, 183,
 184, 199, 203, 205, 221, 286
 psychopathology, 135
 psychoses, 104, 251
 psychosexual problems, 23
 psychosis, 71, 103, 104, 195, 235, 250, 252, 260, 299
 psychosocial development, 3, 123, 178, 196
 psychosomatic, 69, 80, 81, 126, 135, 139, 160, 187,
 188, 189, 190, 191, 196, 197, 201
 psychotherapy, xviii, 26, 32, 34, 59, 68, 71, 75, 76,
 90, 96, 99, 101, 102, 104, 105, 110, 111, 120,

132, 138, 139, 142, 144, 173, 183, 193, 203, 204,
 209, 210, 212, 213, 218, 219, 220, 221, 222, 223,
 232, 258
 PTSD, 239, 288, 300
 puberty, 130
 pubis, 194, 199
 public health, 126, 310, 315, 316, 317
 public service, 315
 publishing, 164
 punishment, 150, 166, 271
 purification, 136
 P-value, 85, 86

Q

qualifications, 192
 quality control, 284
 quality of life, xiii, 9, 37, 38, 39, 41, 43, 44, 46, 47,
 48, 49, 50, 51, 53, 54, 55, 59, 60, 61, 62, 63, 64,
 65, 67, 68, 69, 70, 71, 72, 74, 75, 76, 77, 79, 80,
 81, 85, 87, 89, 90, 91, 93, 95, 100, 102, 103, 104,
 105, 110, 111, 115, 116, 117, 119, 120, 125, 126,
 138, 140, 141, 143, 144, 148, 149, 153, 154, 155,
 160, 164, 165, 170, 171, 182, 183, 192, 196, 199,
 202, 204, 205, 221, 223, 232, 234, 240, 243, 244,
 245, 247, 252, 253, 254, 258, 288, 289, 291, 292,
 293, 297, 299, 300, 301, 305, 309, 310, 311
 quantum chemistry, 144, 184, 222
 questionnaire, 41, 42, 43, 50, 53, 54, 55, 56, 62, 64,
 77, 82, 87, 92, 93, 94, 120, 167, 183, 305, 311

R

radiation, 194
 radiation therapy, 194
 rape, 21, 56, 59, 61, 62, 75, 100, 110, 139, 163, 176,
 177, 178, 181, 184, 195, 199, 200, 215, 217, 226,
 231, 232, 235, 238, 239, 244, 251, 252, 257, 258,
 266, 270, 272, 276, 288, 289, 292, 295, 300
 rash, 247, 249
 rating scale, 43
 rationality, 137
 reactions, 27, 104, 174, 191, 193
 reactivity, 112
 reading, 189, 259
 reality, 26, 54, 149, 165, 193, 216, 225, 232, 258,
 262, 285, 311
 recall, 61, 62, 133, 139, 236, 258
 reception, 197
 recognition, 17
 recommendations, xvii, 35, 111, 184, 192

recovery, 64, 77, 95, 140, 142, 161, 205, 236, 239, 252, 258, 287, 301

rectocele, 29

rectum, 29, 135, 249, 268, 272, 273, 274, 275, 279

regression, 26, 43, 56, 64, 71, 90, 105, 135, 178, 179, 211, 213, 214, 216, 217, 220, 231, 238, 244, 251

regulations, 74, 105

rehabilitation, 21, 102, 111, 115, 116, 119, 136, 141, 152, 153, 170, 171, 172, 176, 177, 178, 216, 246, 299, 305, 315

Reich, Wilhelm, xvi, 26, 68, 168, 191, 195, 198, 214, 226

Reichian therapy, xvi, 192

rejection, 149, 165, 176, 197

relationship quality, 112

relatives, 235

relaxation, 28, 132, 148, 163, 168, 169, 244, 271

reliability, 56, 298

relief, 89, 189, 227, 266, 282

religion, 59, 100

REM, 239, 288, 300

remission, 64, 132, 142, 161, 201, 204

repair, 39, 278

repression, 3, 23, 38, 61, 129, 132, 133, 134, 135, 138, 154, 167, 170, 173, 175, 179, 180, 181, 189, 197, 201, 234, 246, 251, 257

reproduction, 150, 151, 166, 167, 168

reproductive organs, 237

repulsion, xvi, 3

reputation, 212

requirements, 31, 286

researchers, xvi, 26, 28, 30, 31, 32, 68, 91, 107, 132, 232

resistance, 25, 68, 69, 88, 102, 108, 109, 136, 150, 166, 177, 191, 194, 197, 199, 226, 229, 236, 274

resolution, 197, 198, 211

resources, xiii, 39, 61, 103, 137, 194, 231, 234, 238, 243, 244, 245, 246, 247, 251, 252, 258, 287, 292, 298, 310, 311, 312

response, 25, 28, 30, 42, 43, 76, 101, 107, 116, 125, 131, 143, 154, 173, 174, 182, 252, 257, 309, 311

restoration, xvii, 33, 76, 113, 142

restrictions, 219

retirement, 57

retirement pension, 57

rewards, 213

rights, 133

rings, 281

risk, 110, 123, 124, 125, 126, 142, 195, 260, 311

risk factors, 110, 126

risk-taking, 123, 124

roots, 26, 159, 173, 179, 198, 213, 238

rubber, 262

rules, 30, 31, 108, 202, 218, 219

S

sadism, 69, 129, 134

sadness, 88, 266

safety, 31, 71, 90, 105, 150, 166, 232, 249

samplings, 32

scabies, 199

Scandinavia, 305, 310

scar tissue, 29, 69, 243, 244, 271, 292

scarcity, 210

schizophrenia, xviii, 17, 26, 33, 35, 112, 136, 142, 198, 205, 215, 220, 246

schizophrenic patients, 211

school, 124, 125, 126, 202, 216, 236, 247, 248, 265, 266, 269, 317

science, xv, xvi, xviii, 26, 63, 64, 75, 96, 132, 143, 155, 169, 183, 192, 206, 226, 240, 253, 286, 289, 301, 316

scientific papers, 305

scientific sexology, xv

scientific understanding, xiii

security, 31

self esteem, 81, 171, 187, 188, 200, 201, 233

self-awareness, 77, 184, 205

self-confidence, 24, 38, 202, 233

self-control, 152

self-destruction, 135

self-efficacy, 125

self-esteem, 42, 71, 75, 100, 103, 104, 110, 111, 125, 144, 152, 153, 167, 170, 177, 188, 200, 201, 202, 205, 223, 227, 233, 236

self-image, 155, 182

self-worth, 38, 201

semen, 147, 150, 151, 165, 167, 168, 196, 197

sensation, 25, 27, 90, 99, 190, 193, 212, 247, 264, 266, 270, 272, 273, 274, 275, 276, 278, 279

senses, 227

sensing, 280

sensitivity, xvii, 28, 34, 35, 56, 76, 112, 142, 203

sex, xv, xvi, 7, 9, 11, 12, 13, 24, 26, 28, 31, 32, 41, 42, 44, 45, 46, 47, 69, 75, 89, 107, 111, 124, 125, 131, 133, 134, 136, 140, 150, 151, 152, 154, 155, 156, 164, 166, 167, 168, 170, 171, 172, 173, 175, 176, 178, 179, 180, 181, 182, 183, 184, 191, 195, 196, 200, 201, 202, 210, 211, 212, 218, 219, 227, 236, 237, 247, 248, 252, 264, 265, 266, 268, 272, 273, 278, 285, 286

sex differences, 184

sexological bodywork, xvi, 137

sexological examination, xvi, xvii, 27, 28, 29, 30, 31, 32, 34, 68, 69, 74, 75, 76, 99, 102, 106, 107, 108,

- 110, 112, 113, 137, 140, 142, 187, 189, 192, 193, 194, 195, 196, 202, 203, 205
- sexological examinations, 27
- sexological patient, 30
- sexological treatment, xv, 23, 30, 31, 32, 67, 68, 70, 74, 109, 138, 148, 174, 196, 203, 232, 291, 293
- sexologists, xv, 30, 110, 137, 148, 160, 164, 191, 192, 195, 244
- sexology, xiii, xv, xvi, xvii, xviii, 1, 21, 23, 24, 26, 28, 33, 34, 37, 64, 67, 68, 69, 70, 71, 72, 74, 75, 76, 80, 90, 94, 96, 99, 100, 101, 102, 105, 107, 109, 110, 111, 113, 120, 132, 137, 139, 140, 142, 148, 154, 156, 161, 164, 170, 171, 181, 182, 183, 187, 189, 192, 194, 195, 198, 199, 203, 205, 209, 214, 220, 221, 226, 232, 234, 238, 239, 244, 245, 246, 252, 253, 254, 266, 289, 299, 301, 305
- sexual abuse, 3, 32, 71, 81, 88, 90, 103, 105, 110, 124, 138, 139, 150, 159, 166, 173, 174, 176, 177, 188, 191, 194, 195, 215, 217, 218, 219, 221, 225, 226, 227, 228, 231, 236, 237, 238, 243, 244, 246, 249, 251, 252, 258, 287, 288, 291, 292, 294, 295
- sexual activity, 44, 74, 91, 106, 125, 150, 165, 168
- sexual assaults, 59, 61, 62, 232, 258, 264, 266
- sexual behaviour, 31, 112, 154, 170, 172, 216, 286
- sexual contact, 167, 209
- sexual desire, 29, 41, 42, 43, 45, 48, 49, 50, 67, 70, 81, 82, 83, 87, 88, 89, 90, 91, 92, 110, 131, 151, 154, 164, 167, 170, 174, 209
- sexual development, 26, 109, 123, 124, 131, 133, 166, 177
- sexual dysfunctions, xvi, 23, 26, 28, 29, 31, 32, 33, 42, 68, 74, 75, 100, 102, 110, 175, 181, 188, 194, 195, 199
- sexual experiences, 175
- sexual feelings, xvi, 90, 201, 210, 212, 216, 227
- sexual harassment, 59, 61, 62, 154, 171, 173, 247
- sexual healing, xv, 33, 67, 69, 108, 196, 202, 209, 210, 211, 220, 226, 228, 239, 258, 292
- sexual health, xvi, 147, 154, 155, 170, 177, 178, 182, 196, 200, 217, 252
- sexual intercourse, xvi, 7, 79, 81, 83, 87, 92, 131, 133, 148, 163, 179, 213, 244
- sexual motivation, 163
- sexual orientation, 44
- sexual problems, xv, 24, 32, 33, 41, 42, 45, 47, 48, 50, 51, 67, 68, 69, 70, 72, 73, 74, 75, 79, 81, 87, 91, 100, 107, 108, 116, 117, 118, 120, 129, 137, 140, 147, 148, 152, 161, 164, 167, 170, 171, 175, 181, 182, 193, 199, 214, 215, 234, 246, 252, 258, 289
- sexual violence, 178, 181, 259
- sexually transmitted infections, 124
- shame, xvi, 87, 88, 89, 99, 100, 101, 110, 130, 152, 160, 170, 172, 175, 177, 181, 188, 193, 194, 197, 201, 210, 213, 227, 233, 238, 250, 268, 281
- shape, 25, 89, 200, 201, 282
- showing, 55, 88
- shyness, 172, 201
- side effects, 29, 30, 31, 75, 79, 82, 87, 91, 92, 99, 103, 104, 116, 119, 142, 189, 190, 203, 204
- signs, 82, 103, 104, 109, 154, 170, 251
- skeletal muscle, 188, 190
- skeleton, 268
- skin, 58, 187, 200, 236, 268
- skin cancer, 58
- skin tags, 200
- slaves, 275
- social network, 37, 219
- social problems, 59, 310
- social relations, 43
- social relationships, 43
- Social Security, 57
- social support, 126
- social theory, 155, 182, 252
- social workers, 221
- society, xvi, 3, 59, 126, 147, 178, 179, 217, 270, 310, 316
- software, 309
- solution, 9, 23, 26, 33, 50, 148, 172, 174, 176, 227, 275
- sovereignty, 177
- specialists, 125, 194, 232
- speech, 10
- sperm, 179, 264, 268, 272, 274
- sphincter, 27
- spiritual wisdom, xvi
- spirituality, 179, 312
- spontaneity, 260
- squamous cell carcinoma, 200
- stars, 214, 268
- starvation, 130, 135, 136, 310
- state, 39, 61, 62, 71, 88, 99, 103, 118, 124, 129, 132, 133, 135, 149, 165, 173, 174, 181, 190, 198, 210, 216, 217, 226, 234, 245, 246, 248, 251, 258, 260, 292, 293, 294, 295, 297, 298, 299
- state of shock, 234
- statistics, 3, 74, 118, 119, 213, 309
- sterile, 32, 187, 188, 197, 200
- stimulation, 26, 27, 28, 29, 68, 69, 74, 76, 99, 100, 101, 102, 104, 105, 106, 107, 108, 109, 110, 137, 138, 143, 176, 194, 195, 196, 197, 202, 214, 215, 221
- stimulus, 112
- stomach, 11, 130, 132, 135, 172, 196, 247, 248, 249, 263, 268, 269, 272, 273, 274, 275

- stratification, 61
 stream of consciousness, 260, 294
 stress, 25, 37, 65, 77, 90, 95, 111, 112, 120, 126,
 141, 143, 155, 183, 205, 220, 221, 223, 233, 238,
 239, 286, 287, 288, 300
 stressors, 37
 stretching, 29, 100
 stroke, 280
 strong female Oedipus complex, 3, 225, 226
 structure, 21, 33, 76, 101, 140, 144, 147, 148, 149,
 150, 152, 155, 165, 179, 182, 183, 199, 222, 240,
 253, 289, 293, 298, 301
 style, 102, 199, 311
 subgroups, 32, 87
 subjective experience, 17, 168
 substance abuse, 239, 288, 300
 substance use, 124
 success rate, 229
 suicide, 58, 71, 103, 124, 125, 236, 259, 260, 283,
 285, 286, 287, 292, 299
 suicide attempts, 71, 103
 superego, 226
 supervision, 70, 71, 74, 82, 91, 103, 105, 106, 215,
 251, 259, 286
 supervisor, 103, 105, 191, 192, 237, 286
 suppression, 160, 173
 suprapubic, 27
 surgical intervention, xviii, 34
 surplus, 238
 survival, 13, 39, 172, 176, 204, 216
 survivors, 143, 184, 238, 239, 288, 300
 sweat, 283
 Sweden, 204, 317
 symbolic meanings, 196
 symptoms, 7, 8, 13, 14, 17, 21, 29, 32, 41, 59, 60, 70,
 82, 87, 106, 129, 131, 136, 137, 138, 139, 188,
 189, 191, 197, 212, 213, 225, 226, 227, 228, 233,
 237, 251
 syndrome, xviii, 32, 34, 35, 67, 70, 187, 188, 200,
 238, 288
 synthesis, 132, 169
 syphilis, 199
- T**
- talent, 76, 140, 149, 151, 155, 164, 167, 181, 182,
 220, 234, 239, 243, 244, 245, 253, 289, 292, 301
 talk therapy, xv, 91, 187
 tantra, xv, 23, 27, 95, 96, 168, 212, 217
 teachers, 222
 techniques, 29, 68, 74, 91, 105, 192, 194, 195, 223,
 266
 technology, xvii, 34, 94, 112, 221
- teenage girls, 129
 teens, 192
 teleological, 285
 telephone, 270, 281
 temperature, 283
 tension, 12, 26, 28, 29, 89, 90, 116, 130, 133, 135,
 151, 152, 154, 163, 167, 168, 169, 170, 171, 200,
 212, 217
 testing, 70
 test-retest reliability, 56, 184
 textbook, 68, 305
 theatre, 58
 therapeutic conversation, xvi, 167
 therapeutic process, 101, 202, 235, 259
 therapeutic relationship, 210, 219
 therapeutic touch, xvi, 64, 100, 111, 136, 137, 141,
 160, 187, 190, 192, 193, 194, 196, 203, 204, 211,
 213, 215, 218, 220, 221, 239, 243, 244, 289, 292,
 301
 therapist, xiii, 28, 30, 31, 69, 70, 71, 88, 89, 90, 99,
 100, 102, 103, 104, 105, 106, 108, 109, 136, 137,
 139, 173, 174, 175, 176, 177, 178, 191, 192, 196,
 202, 209, 210, 211, 212, 213, 215, 216, 217, 218,
 219, 220, 226, 227, 228, 229, 232, 233, 235, 245,
 246, 251, 258, 259, 260, 271, 273, 278, 284, 286
 thinning, 188
 third dimension, 149, 165
 thoughts, 59, 130, 213, 229, 236, 246, 250, 257, 273,
 274, 283, 286, 293
 tinea cruris, 199
 tinnitus, 141
 tissue, 29, 101, 175, 189, 190, 197, 234, 245, 271
 top-down, 144, 184, 222
 torture, 163, 177, 178
 touch therapy, xv
 trachea, 278
 trade, 150, 166
 training, 28, 71, 74, 81, 90, 91, 102, 105, 106, 109,
 154, 171, 172, 192, 199, 215, 243, 244, 249, 251,
 259, 292, 310
 transcendence, 168
 transference, xvii, xviii, 3, 26, 35, 69, 101, 103, 111,
 112, 173, 174, 184, 209, 210, 211, 212, 214, 215,
 217, 218, 219, 220, 225, 226, 228, 286, 293
 transformation, 202, 216, 260, 297, 298
 transition to adulthood, 123
 translation, 80
 translocation, 135
 trauma, 25, 75, 80, 95, 115, 116, 137, 139, 159, 160,
 170, 176, 181, 184, 200, 201, 218, 223, 225, 226,
 227, 229, 231, 233, 234, 235, 237, 238, 239, 249,
 251, 252, 278, 288, 292, 294, 295
 traumatic events, 137, 235, 237, 291, 299

trial, 64, 112
 trichomonas, 199
 tumors, 200

U

ulcer, 59
 ultrasound, 69
 umbilical cord, 264
 unhappiness, 171
 unification, 179
 united, 82, 204, 305, 317
 United Kingdom (UK), 204, 317
 United States (USA), 82, 101, 147, 305
 universe, xiii, 24, 169, 198, 213, 279
 urban, 126
 urethra, xvii, 34, 129, 133, 135, 138, 140, 188, 197, 205
 urinary tract, 80, 129, 138, 187, 197, 200
 urinary tract infection, 197
 urinary tract inflammation, 187, 200
 urine, 95, 136, 199, 248
 uterus, 29, 81, 89, 106, 188, 196, 248, 266, 280

V

vagina, xviii, 24, 25, 27, 29, 30, 31, 34, 75, 79, 80, 81, 87, 90, 91, 92, 94, 100, 106, 107, 111, 135, 138, 140, 175, 183, 187, 188, 192, 194, 195, 196, 197, 200, 205, 221, 249, 250, 251, 254, 257, 259, 260, 266, 270, 272, 273, 275, 276, 286, 289, 292, 301
 vaginal acupressure, xvi, xviii, 28, 30, 34, 67, 69, 75, 79, 80, 81, 83, 88, 91, 92, 95, 100, 111, 140, 183, 205, 211, 214, 215, 221, 266
 vaginal massage, xvi, 28, 68, 95, 100
 vaginitis, 188
 validation, 56, 77, 120, 183
 variables, 51, 55
 venereal disease, 59, 277
 Viagra, xvi, 23, 24, 26, 27, 31, 32, 33
 victimization, 124, 126, 232, 239, 288, 300
 victims, 61, 63, 159, 195, 232, 236, 238, 239, 257, 259, 288, 291, 300
 videos, 101
 violence, 56, 59, 124, 250, 294
 viral infection, 199
 visualization, 228
 vitiligo, 200

voiding, xviii, 35, 112
 vomiting, 95, 127, 130, 132, 135, 248, 276
 vulnerability, 7, 13, 61, 63, 88
 vulva, 29, 89, 92, 96, 101, 102, 104, 106, 175, 187, 188, 189, 190, 191, 192, 193, 194, 196, 197, 198, 199, 200, 201, 202, 203, 257, 266
 vulval pain, xvi, xviii, 34
 vulvitis, 188
 vulvodynia, xvi, 64, 67, 70, 75, 81, 89, 96, 110, 116, 124, 127, 139, 152, 156, 161, 163, 175, 181, 182, 187, 188, 197, 199, 202, 205, 221, 239, 253, 289, 301

W

waking, 10, 271, 273
 walking, 270
 war, 231
 waste, 10, 236, 270
 water, 13, 136, 264, 270, 282
 weakness, 23, 24, 87
 web, 152, 180
 weeping, 246, 247, 265
 weight control, 130
 weight loss, 127, 130
 welfare, 305, 315
 well-being, xiii, 12, 37, 43, 44, 46, 55, 100, 103, 107, 196, 305
 Western countries, 3
 WHO, 184
 withdrawal, 130, 216
 workers, 276, 286
 worldview, 149, 165
 worms, 274
 wrists, 269, 283

Y

yield, 55, 112
 young adults, 160
 young people, 3, 75, 120, 140, 147, 154, 161, 182, 252, 289
 young women, xvi, 129, 135, 139, 188

Z

zygote, 168, 180, 248