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Five tools for manual sexological examination: Efficient treatment of genital and pelvic pains and sexual dysfunctions without side effects

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Abstract

Manual sexology is clinical, holistic medicine focused on sexual healing. Sexual healing occurs when the patient understands and assumes responsibility for the disturbances in her psychosexual development. The tools can be categorized as small and large tools of manual sexology, with comparison to the pelvic examination. This paper reviews five tools for examination and the simultaneous treatment of the patient (i.e. clinical medicine): 1) "Acceptance through touch" is therapeutic touch in sexology, where the therapist gives the acceptance to the patient on a sexual and bodily level that she needs but did not get from her parents, 2) Vaginal acupressure (Hippocratic pelvic massage) is massage of the organs of the pelvis through the vagina, which helps the patient to get present in the lower parts of her body and integrate repressed negative feelings and emotions often related to sexual traumas. Hippocrates and his students used this method 2,300 years ago for the treatment of hysteria, 3) The pelvic examination is itself highly therapeutic but only if the physician or gynecologist addresses the emotions it provokes, 4) The holistic pelvic examination is the pelvic examination done in an empathic and therapeutic way, 5) The sexological examination, often called the "educational, gynecological, sexological examination" is a yet more complicated and time consuming and also more therapeutic procedure that involves the exploration of the patients sexual energies, character, sexual problems, sexual history and also use the large therapeutic tool of direct sexual stimulation of the patients clitoris and vagina. This tool can often bring a chronic, an-orgasmic patient all the way back to orgasmic potency in short-term therapy. It has been used for sexological research, but has so strong curative qualities that it potentially could help many patients, who are not sufficiently helped with the smaller sexological tools. The ethical and legal aspects of the manual sexological tools are discussed.

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Introduction

The pains and discomforts and problems related to the organs of the female pelvis like the female sexual pain disorders, vulvar vestibulitis syndrome, dyspareunia and vaginismus have been variously classified through time as sexual disorders, pain disorders, psychosomatic disorders or urogenital disorders (1). The ambition to create a precise diagnostic system for these pains, discomforts and dysfunctions have largely failed (see 2,3) and the complexity of the matter remains basically a mystery for both the clinician and the researcher. The fundamental lack of scientific understanding of the female problems has lead to a severe lack of sufficient treatment. About on third of the women in the western work have in spite of seeing their doctor on a regular basis, recurrent complaints or chronic conditions related to the organs of the pelvis, especially the genitals, bladder and muscular system, which are obviously not cured or even helped much by the standard biomedical examination and treatment (4).

The problems of the female patient have been important issues from the beginning of medicine; the famous physician Hippocrates and his students used pelvic massage and similar treatments for a vast number of such female illnesses and health conditions, which were already at that time related to problems with the sexual energies of the womb and the general psychosexual development of the mature female character and sexuality (5). Since the development of modern sexological science around 1950, such manual sexological procedures as pelvic massage have again been acknowledged by physicians as efficient medical tools for a number of sexual problems, pelvic and genital pains, and other dysfunctional conditions in the pelvic area (6-13).

Since Freud and Jung repressed libido and sexuality has been seen as a primary cause of many mental and physical problems (14,15); quite surprisingly these researchers seemed to be in accordance with the Hippocratic tradition in their understanding of sexuality and its fundamental importance for human health. In contrast to this holistic medical tradition, we have the biomedical science that does not see sexuality, but biochemistry and genes as a leading cause to the patient's mental and somatic health problems; this understanding has lead to a large number of pharmaceuticals, which most unfortunately does not seem able to help most of the female patients with problems related to sexually and the energies in the pelvic area. While Freud's psychoanalysis uses only talking (14), manual sexology much inspired by Reich (6) often used bodywork, often focused on the genitalia, to free the repressed sexuality and painful emotions that have caused the problems.

Many pains and discomforts of the pelvic organs are not well understood today. It is a fair guess that repressed emotions related to sex (including the oral and anal aspects described by Freud) also causes many of the most common problems like the urinary tract infections (UTIs) and the genital tract pseudo-infections, that mimics the UTIs, but has no bacteria (or insufficient bacteria to explain the symptoms). 50% of women have these symptoms at some occasion and it has been estimated that half of the GTI are actually sterile inflammations caused by something else that bacteria (16). Most likely the inflammation is simply caused as a somatisation of the sexual blockages caused by difficult repressed sexually related emotions.

The general practitioner or gynecologist will therefore be well advised to always look for a psychosomatic, sexual cause for recurrent or chronic pelvic or uro-genital pain or discomfort. The most efficient way to look for this is by using the combined exploration and treatment known as the classical "sexological examination" (6-13). Most unfortunately this examination is highly complicated and takes 30-90 minutes even for a trained physician.

To make sexology more ethical, rational and also more customized to the needs of each individual patient, and to make it possible in the future to treat the many female patients with such conditions also in a general practice with more limited time for such procedures that the sexological clinic, we have during the last 10 years developed smaller and faster tools than the thorough, traditional sexological examination.

During this period of research at the Research Clinic for Holistic Medicine in Copenhagen we have found, that about 40% of the female patients with problems in the pelvic area can be cured just with the

smallest of these tools, acceptance through touch (17), and about 60% can be cured with vaginal acupressure (also called Hippocratic Pelvic Massage), where the patients resistance is addressed and analyzed (18,19). Most interestingly we found that the pelvic examination has a large therapeutic potential in itself, if it is used wisely, and its healing potential is exploited (20), but the strong traditions of this procedure make this somewhat difficult. A therapeutic element can after the patient's consent be added to this procedure, which we have found to be a great help for patients, who needs a more empathic style of pelvic examination, i.e. because of sexual traumas. Finally, the large full-scaled sexological examination can be used to help the patients that cannot be helped by these smaller tools; this procedure includes the provocative tool of direct sexual stimulation of the female patient (6-13); the use of this dramatic tool is justified by a curative rate of about 90% of the patients with chronic conditions like anorgasmia (21).

The ethical principle of using the smallest tool that helps the patient must always be remembered. It is also important to discriminate the different tools accurately to get the consent from the patient to exactly the planed procedure. A smaller procedure makes it easier for the patient to participate, making sexological therapy possible even for the patients that have been severely traumatized sexually, i.e. by rape or incest.

It should be mentioned that a substantial fraction of the patients – we estimate one in three - who realize that their problem is related to a disturbed, psychosexual development, can be helped without any manual sexological treatment, but just with a combination conversational of therapy and customized exercises (22-24).

This is easier if the patient already has a sexual partner to do exercises with, the lack of which is often an important part of the problem. The use of non-sexological bodywork in clinical holistic medicine will often speed the treatment up also of sexological problems, and reduce the number of sessions it takes to help the patient, and it might also increase the fraction of patients being cured to about 40% (25). Research has shown that psychotherapy in general is less efficient to cure sexual dysfunction than sexological therapy (26).

Five tools for manual sexology

The five tools for manual sexology are listed in table 1. Before a manual sexological tool is used it is wise to get written consent, and also not to be alone with the patient during therapy. It is important to measure the state of sexual dysfunction or pain with a simple questionnaire like the QOL10 (27) or a visual analog scale, to document the effect of the treatment, and also to know when to step up and use a larger tool because the on in actual use is not working.

Table 1. The five tools for manual sexology. These tools should only be used when conversational therapy, anatomical education, sexual biography etc. have failed to solve the problem, and then the smallest tool that can cure the patient should be used (28)

1.	Acceptance though touch
2.	Vaginal acupressure
3.	Pelvic Examination
4.	Holistic Pelvic Examination
5.	Sexological examination

1. Acceptance though touch

This procedure of accepting therapeutic touch (6-13,17,30,31) is the most basic tool of sexology, as it just gives acceptance to the patient's body. In principle the accepting touch can be applied everywhere; just holding the patients hands with great acceptance is highly therapeutic. To make this tool more efficient it can, after consent made before the session starts to avoid that the patient feeling overwhelmed, or even exploited or abused, be used directly on vulva; it is wise to start by putting the patients own hand on her vulva and the sexologists hand on top of hers; it is also wise to start by doing it with the clothing on and having a nurse in the room also. If this does not help the patient, the patient is asked to undress, and the vulva can be treated in a quiet, calming manner. In this process the therapist take the role of a caring parent and give as much as possible his unconditional love and acceptance to the patient, her body and her sexuality.

Just the experience of finally getting the acceptance that she never got from her parents can make small miracles happen; if the patient suffers from a sexual aversion disorder or low sexual self esteem, this procedure will often be experienced as a very strong intervention, in spite of its minimal size as a therapeutic tool, and the effect can be surprisingly large.

To understand the therapeutic value of *acceptance though touch* one should remember that the patient did not get the acceptance of her body, gender, genitals and sexuality she needed for not repressing her sexuality and sexual feelings; the traumatic repression happened in childhood every time she was overwhelmed by negative emotions that she could not contain. These sexual traumas are often not connected to physical abuse, but they can be. Almost all international studies made during the last decades have documented that about 15% of females have been sexually abused in their childhood (see 30). Therefore such traumas are not uncommon at all and must be expected with one in two or three of the female sexological patients, as the traumatized patients are much more likely to have problems in the pelvic area. The reason for the strong therapeutic effect of such a simple tool as acceptance through touch is that it gives resources to the processing and integration of sexual traumas, also when these are not caused by abuse, but simply by sexual neglect, which often is equally traumatic as abuse (31). The surprisingly simple tool of "acceptance through touch" thus often opens up for a constructive and therapeutic dialog about the patient's sexual history. A sexual trauma that comes from the dramatic events of incest or rape are often more deeply repressed, and take time and often also larger tools to cure like the sexological examination (see below).

2. Vaginal acupressure

This intervention is actually the classical Hippocratic vaginal massage; it is most simply done as the explorative phase of the normal pelvic examination with a focus on the feelings and negative emotions associated to the different places, anatomical structures, tissues and organs in the pelvis, including the muscles and the outer and inner genital structures. The penetration of vagina symbolizes the intercourse (14), and the patient's subconscious will often react to the digital penetration similar to the reaction to penile penetration. Therefore just penetrating the vagina with one or two fingers already put the female patient in a position, where all the difficult and painful emotions connected to sex can be exposed and processed.

A few dysfunctional patients react with sexual arousal on this procedure, but most react with resistance. About half of all sexual problems and genital pains can be cured just by addressing and processing the repressed emotions and feelings behind this resistance, as already discovered by Reich (6). Sometimes the procedure needs to be repeated, while layer after layer of repressed material are integrated (32-34). Again a nurse should be in the room also.

3. The pelvic examination

It is well-known that female patients with sexual traumas often react negatively to this procedure (35); many of these patients complain that they feel the pelvic exam as humiliating and traumatic in itself. If that is the case, a smaller tool must be used, until the resistance towards the pelvic examination is reduced to a manageable level. The negative emotional reaction is coming from the strong similarity between the pelvic examination and many sexually charged and traumatizing elements, like being controlled, being looked at, being penetrated in a vulnerable position, being penetrated with a large, hard, physical object (the vaginal specula), being tortured (pain from the procedure, both from penetration and different sorts of tests taken). The deep exploration of the uterus including the visual inspection of the portio vaginalis cervicis uteri is often extremely provocative, as "nothing is left uncovered".

This is in essence a complete exposure of the patients, and it demands a high level of trust and a complete emotional and behavioral surrender of the patient to the physician or gynecologist making the examination. Using the therapeutic value of the pelvic examination is not difficult at all; all it takes is an honest talk with the patient about what the different aspects of the examination procedure symbolizes, and what this does to her emotionally. The problem here

is that the patient often has been to gynecologists with some in denial about the provocative and potentially traumatic dimension of this procedure; she will be very surprised to finally meet a therapist that acknowledge the emotional aspects of it and cares to explore the emotional roots of her reactions to the procedure. As the emotional response to the standard pelvic examination often is a rather large and actually somewhat hard to integrate emotionally for most patients with sexual problems, it is wise to start with a smaller tool, if the intent is exploring and curing issues related to sexuality. Again a nurse should also be in the room during examination.

4. Holistic Pelvic Examination

Instead of using a smaller tool like acceptance through touch or vaginal acupressure, the pelvic examination can be done in a slow and emphatic way, where the patient gets the time she needs to accustom to every step of it. If this is done with patients with sexual traumas it can be extraordinary therapeutic, but the session can take one or even several hours, and this is often not possible in a busy clinic with limited professional resources. We have found that this procedure can change the patient's biology at a very profound, even hormonal, level, so it sometimes even cures involuntary infertility of psychosomatic origin (20). Basically what makes this intervention "holistic" is the "love and care" for the patient that allows her to take part in everything that is happening in the consultation hour.

The pelvic examination can according to our experiences when used in this therapeutic way help patients with sexual desire problems, sexual arousal problems, lubrication problems, lack of sexual pleasure, negative feelings about sexual interaction, genital arousal disorder, lower genital arousal associated with intercourse, pain due to psychosocial factors, deficient pelvic muscle control etc. A nurse should be present during the examination.

5. Sexological examination

There are various kinds of sexological examinations, but the following is often used and it was created in 1965 by Hartman, Fithian and Morgan (8,10,12) and inspired by Reich, Hoch and Kegel (6,7,11,12). The sexological examination was designed to evaluate and assess the various components of human sexuality (e.g., perception, feeling, arousal, and response patterns) present or absent in varying degrees in research and therapy populations. The examination was a supplementary to the examination given by a gynecologist or other medical specialist. The objectives of the examination include (8,10,12,13):

1. Providing a learning experience in physiological psychology for a husband and wife, committed partners, or singles.
2. Dealing with the self-concept of women who want to know, "Am I normal?" "Is my clitoris/labia too big or too small?"
3. Teaching women specific vaginal exercises.
4. Giving the therapist a clear picture of the response patterns of the subject through verbal reports of sensations to stimulation in each area of the vagina.
5. Identifying, where present, causes of dyspareunia and pain in the female. Some pain or discomfort may be psychological.
6. Giving genitalia their correct anatomical names.
7. Making the individual more at ease with her sexuality and sexual functioning.
8. Enhancing communications between couples about genitalia and functioning.
9. Overcoming the reluctance by some individuals to have non-intercourse genital contact, such as touching the penis or putting a finger in the vagina.
10. Helping the patient to intimately explore own (and partners) genitals.
11. Teaching the use of other techniques to be used later during treatment, in privacy, where they may be carried on to fruition. This, for example, might include the squeeze technique.
12. Explaining other sexual options where, in private, the partner may stimulate the spouse to climax without the use of the penis.
13. Observing psychological conditions and responses to be treated during the therapy.

14. 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.
15. Checking the clitoris to see that it is free of adhesions. Women typically say their physician has never examined it.
16. Searching for areas where nerve endings come together in a systematic way, suggesting that this may develop positive feelings.
17. 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).
18. Determining a woman's response and arousal patterns. Indicating to her whether or not she lubricates well and vasocongests when she does.
19. 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.
20. Identifying, where present, reasons for vaginismus, which are not only physiological but psychological.
21. Teaching a male partner how to caress the female's vagina.

The most radical aspect of the sexological examination and what makes it different from the other manual sexological procedures is that it involved the technique of direct sexual stimulation. “Direct sexual stimulation of a client toward a high level of arousal is not, and never has been, a part of the sexological examination conducted at our Center. Still, some women do become aroused, and occasionally a sex flush will be observed in the process practice of the vaginal caresses according to Hartman and Fithian (13).

The sexological examination is also examining the clitoris: “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 pre-orgasmic 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” (13).

The sexological examination is explicitly sexual, and it addresses all relevant issues of sexual nature, and the female patients sexual responses are tested in the clinic directly by letting the patient feel sexual desire, arousal and pleasure, and report on it. The sexological examination can be taken all the way to instant sexual healing of the female an-orgasmic patient who cannot by herself get an orgasm. This technique has been used for 30 years by sexologists like Betty Dodson in the USA and Denmark and is still considered highly controversial in spite of its extreme efficiency, allowing therapists like Dodson to cure about 90% of the female patients with chronic anorgasmia, in only 15 hours of intensive therapy (21).

Ethical and legal considerations

The major concern that professionals have about the sexological examination is that untrained or unethical therapists might use it unwisely (6-13). Manual sexology must therefore be performed according to the highest ethical standards. The holistic sexological procedures are derived from holistic existential therapy, which involves reparenting, 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.

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”) (27), but we understand that the more radical, manual sexual procedures are not accepted in many countries due to the sexual taboo. But no culture has the power to forbid the physician to touch his patient, and every time there is

a touch, acceptance can be given. So every physician and therapist in every culture of the planet can use the smallest of the manual sexological tools. The physician or therapist is well advised to adjust his practice to the laws of the country.

To perform the sexological techniques, the sexologist must be able to control not only his/her behavior, 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 the presence of a third person. We recommend the ethical rules of the International Society for Holistic Health to all practitioners of sexology, bodywork, and clinical medicine (27).

We will ask the reader of this paper who is left with the feeling that manual sexology is unethical and potentially abusive, because it allows the physician or therapist to touch the patients genitals, which potentially could be done for the therapists own pleasure and not for the benefit of the patient, to take into the consideration that the patients that seek sexological assistance are doing this consciously, with full consent, and often because they are chronically ill and severely tormented by their sexological health issue. Many of these patients are not able to find a sexual partner and their situation in life seems often pretty hopeless; many of them have been dysfunctional and incurable for many years (we found a mean of 8.9 years in our study of vaginal acupressure (19)), often with chronic pains, and they are depressingly aware that they are suffering from a condition for which there is no efficient biomedical cure, because they often have tried every possible treatment, sometimes even including genital surgery for the pains!

Many of the patients are also unaware of body memory or repressed memory due to earlier traumatic stress (30) and some patients only open their mind up for their earlier sexual abuse through the sexological examination, because the touch becomes the trigger that reconnect body and soul and recovers the patients *sense of coherence* (36,37). Therefore manual sexology has a unique healing potential in a time where sexual abuse and repressed sexual traumas are frequent.

We are aware that manual sexology is still not legal in some countries and find it important for the many sexually traumatized patients, and also for the many patients who got their psychosexual developmental problems for other reasons, who potentially could be cured by the aforementioned five sexological tools, that every country in the future will allow its physicians and therapists to practice these five tools of manual sexology.

Discussion

The primary purpose of sexological therapy is to improve the global quality of life and secondary to improve health and ability, which often happens when sexuality is improved (5,6,14,15). The severe conditions of the patients and the chronicity, and the high efficiency of the sexological procedures, are what ethically justify the much more direct, intimate, and intense methods of manual sexology. The sexological intervention is ideally a holistic procedure also addressing the patients mind and spirit, not only the body; it integrates many different therapeutic elements also from psychoanalysis and short-term psychodynamic psychotherapy (22-24); it works on many levels of the patient's existence and personality at the same time, including spiritual aspects like the character and the meaning and purpose of life (the life mission) (38). We find it therefore correct to call these abovementioned procedures for "holistic sexology" or "holistic existential therapy", and include them in the concept of clinical holistic medicine.

Sexual problems are not only very distressing for the patient; they are also an integrative part of a psychological developmental disturbance that affects the personality of the patient at its roots. Reich wrote about the "genitally mature character", or the "genital character" for short (6), and we have often seen that healing a patient's sexual problems lead to the subsequent healing of the patients mental and existential problems also, indicating that a major reason that many mentally and existentially troubles patients never recover might be the constant repression of their sexuality and libido, as already suggested by Freud and Jung (14,15).

Sexuality is still one of the strongest taboos we have in our western culture, and only if all physicians and health professionals work in concerted action will

we be able to do something about this within a few generations. It might be the missing link to a more healthy population at large.

Psychotherapy must be considered as an alternative to sexological therapy, but there seems to be a general acceptance of the fact that many sexual dysfunctional states are not cured by psychotherapy alone (24), and that sexological procedures are necessary for patients that are non-responders to psychotherapy. Clinical holistic medicine that includes philosophy of life and bodywork are often efficient with sexual problems and seems to be able to cure 40% of these patients only by use of therapeutic touch including acceptance through touch (25).

In psychology, psychiatry, and existential psychotherapy (39,40), touch is often not allowed, and this might be the reason for these treatment methods not being very efficient with sexual dysfunctions.

Conclusions

The toolbox of manual sexology is so varied that there are tools for any occasion and any patient with sexual problems or uro-genital pains and discomfort. If there is not an obvious reason for a problem in the pelvic are, the general practitioner or therapist is well advised in thinking of sexual problems and repressed feelings and emotions relating to sexuality, as these has a strong tendency to become psychosomatic.

There are a lot of different disorders and sufferings that often can be helped or cured by manual sexological procedures: Sterile urinary tract infections, chronic pelvic and abdominal pain, pain and discomfort in the vulva, introitus or vagina, dyspareuni, vulvodynia, anorgasmia, sexual aversion syndrome, infertility patients, sexual desire problems, sexual arousal problems, lubrication problems, lack of sexual pleasure, negative feelings about sexual interaction, genital arousal disorder, lower genital arousal associated with intercourse, pain due to psychosocial factors, deficient pelvic muscle control etc.

Some of the five tools of manual sexology might be too advanced for most general practitioners and therapists and luckily most problems can be solved with the small tools. Just working with awareness and giving acceptance every time a patient is touched is already a huge step forward towards sexual health of our patients. Physicians and therapists who have general concerns about pelvic floor physiotherapy should know that over 50 randomized clinical trials has shown vaginal physiotherapy to be rational and efficient for incontinence, pelvic and genital pain syndromes, etc. without any significant side effects (41), but when it comes to sexual dysfunctions the physiotherapists recommend the sexological examination to improve efficacy.

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