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Somatic-Experiential Sex Therapy: A Body-Centered Gestalt Approach to Sexual Concerns

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ABSTRACT

When I started my studies of sexology and sex therapy in 1973, I was already a practicing Gestalt therapist. At the time, the Masters and Johnson approach primarily defined the field of sex therapy and essentially promoted a cognitive-behavioral method for relieving sexual dysfunction. Though I learned a great deal, especially about what could go wrong, my own focus on growth and on the phenomenology of sexual distress and pleasure cast me in a lonesome position in the world of sex therapy.

It also seemed to me that the split between mind and body that dominated the larger culture was alive and well in the whole of the clinical field. Psychotherapists were supposed to deal with the mind and emotions. The more holistically-inclined included the body. But sexual issues required a separate kind of therapy.

Much has changed in these thirty years, and the unity of mind and body is now widely acknowledged. Yet among clinicians, psychotherapy, bodywork, couples counseling, and sex therapy are often seen as requiring separate therapists and different

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Dedicated to the memory of Elaine Kepner (1920-2002).

modalities. As O'Shea (2000) has pointed out, the failure to deal with sexuality in psychotherapy likely has more to do with "fear and uncertainty" among psychotherapists than it does with sexual issues being irrelevant to the clients and trainees with whom we work. She goes on to suggest that "...the struggles and contradictions of our culture reflect a yearning for a sexuality that is more fully integrated, more connected to our sense of self, that touches people at their deepest level of need...."

This paper explores the possibilities for greater attention to sexual issues as growth issues, and for more integration among these various therapeutic disciplines. In particular, it describes a comprehensive approach to personal growth and satisfaction in relationships that is based in Gestalt theory and practice and includes attention to the body and the sexual self.

The paper begins by identifying several models for approaching sexual concerns in psychotherapy. It continues with an exploration of how a body-oriented Gestalt model—a somatic-experiential approach—differs theoretically and methodologically from more traditional methods. It concludes with a case history demonstrating applications of this approach, and a summary of essential features.

Therapy Models for Sexual Concerns

There are three interrelated but nevertheless distinct perspectives for dealing with sexual concerns in therapy. One views sexual issues as sexual problems; a second looks to enrich sexual intimacy; a third regards sex within a paradigm of personal growth.

Sex as a Problem: A Treatment Model

The most common way to deal in therapy with a sexual issue is to treat it as a problem needing to be fixed. A man wants to overcome premature ejaculation; a woman has difficulty achieving an orgasm or feeling desire for a husband or long-term partner. A couple has very different sexual appetites. To these clients, therapy will be deemed a success if and when they achieve a specific sexual outcome.

The DSM-IV, essentially a medical classification system, naturally approaches sex from a problem perspective. There are the Sexual Dysfunctions, which include Sexual Desire Disorders, Arousal Disorders, Orgasmic Disorders, and Sexual Pain Disorders; the Paraphilias such as Fetishism, Pedophilia, Masochism and Sadism; and Gender Identity Disorders in Children, Adolescents, or Adults.

However, what constitutes "normal" sex may be based more on cultural assumptions than on science. For example, in the case of Female Sexual

Arousal Disorder, a consortium of female sexologists has taken issue with the entire classification. These authors disapprove of a system that, among other "distortions," identifies as a disorder an inability of a woman to attain an adequate response of sexual excitement, without addressing "the relationship aspects often at the heart of a woman's sexual satisfactions" (Tiefer, 2001). Simply put, a woman who failed to get turned on to an emotionally abusive and manipulative husband can hardly be considered to have a sex problem.

When therapy focuses on symptom resolution, the approach is typically cognitive-behavioral—that is, looking for incidents of sexual trauma and misinformation, focusing on the emotionally painful thought patterns that have become associated with sex, and especially, building new sexual skills. This is the Masters and Johnson approach, and it is the basis for the way much of sex therapy continues to be practiced. Goal-oriented solutions to sexual problems can be seen as a treatment model.

Realizing Sexual Potential: An Enrichment Model

Recently some sexologists have moved away from the narrow focus on human sexual inadequacy and the emphasis on defining and treating sexual performance problems, and into a broader investigation of human sexual potential. To sexologist and sex therapist David Schnarch, for example, great sex is defined less by the physical event and more by the quality of intimacy and eroticism a couple can enjoy together. His emphasis in therapy has been on the "differentiation of self," a concept borrowed from Bowen's family systems theory. For Schnarch (1991), the ability to function independently and still be emotionally involved, a key factor in self-differentiation, permits individuals to be close without being fused, and allows for a fulfilling sexual connection in a marriage. In Gestalt terms, the less confluent the relationship and the more contactful the sexual encounter, the greater the likelihood of genuine arousal and passion.

The emphasis on sexual enrichment shifts the focus from achieving certain levels of *performance* to recognizing and sustaining deeply satisfying qualities of *experience*. Rather than maintaining goals about external standards such as frequency of intercourse or orgasm, there is a continual process of personal unfolding. Each partner enhances his or her own ability to sustain desire, to relax and surrender to pleasure, to be fully present, to make good contact, to be a sensitive, intuitive lover, and to be emotionally and physically renewed by the contact.

Occasionally, when conditions are just right, lovers may know true ecstasy, a thrilling sensation of a loss of physical boundaries and a merging together that has been described as spiritual and transformative. As Gestalt therapist Jean Lanier (1989) has written, "There is nothing quite so fulfilling as the ecstasy we experience in truly meeting and joining with

another person in the spirit of reverence for the total being of that person."

Just as we might expect any aspect of our lives to evolve with awareness and practice, so, too, we can legitimately expect the sexual realm of experience to evolve over a lifetime. However, it takes a special regard for the value of sexual vitality, and a lively attentiveness to the sensual/sexual body, to inspire that kind of unlimited sexual development.

Sexual Issues in Personal Development: A Growth Model

Some individuals grow every way but sexually. We all know people who have grown over the years to become wiser, more emotionally available, and more compassionate toward others. Yet their sex lives are in shambles or non-existent.

Some are single, bright, successful, middle-aged, and sexually adolescent. These are the men and women who obsessively pursue sexual conquests or specific body types with little regard for the emotional connection, and who continually bemoan their inability to find true love. Others are couples who share a strong emotional bond, yet sadly admit in private that they lack any sexual connection.

In a relationship, when love and sexuality fail to be integrated, an important element of intimacy is missing. On a more personal level, lack of ease with one's sexuality may also diminish health and physical vitality. Most especially, sealing off an important part of the human experience can form a barrier to a deeper sense of self.

Just as human beings can grow in self-knowledge, self-acceptance, and the ability to love others, so, too, our self-knowledge, self-acceptance, and ability to love, as sexual beings, can grow. The most obvious effect of a greater comfort with sexuality is an enrichment of the ability to give and accept sexual pleasure, particularly in the context of a caring relationship.

Acknowledged less often today is the central role played by early sexual inhibition in the stifling of the authentic self. As long as sexual feelings evoke painful rather than pleasurable feelings, authenticity continues to be compromised. As Kepner (1987) has observed, "If one's sexual nature is denied or distorted, then contact with one's body … and also the fact of one's physicality itself, become denied or distorted, and disowned as self."

Yet, in the current tenor of downplaying sex in psychology, what some have considered Freud's greatest contribution to the field has largely been ignored. Freud's milestone insight, by most accounts, was the recognition that the suppression of infantile and childhood sexuality, especially in the arena of the incest taboo, plays a critical role in shaping the adult personality (Freud, 1962).

As Wilhelm Reich observed, sexual repression also shapes the adult body (1961). Developing a greater sexual awareness can have the effect of

helping to free oneself energetically in the body. For example, when sexual feelings are suppressed, or narrowly and compulsively expressed, the chest as well as the pelvis are often held rigid, particularly in sexual, or potentially sexual, situations. The inability to feel an emotional connection during sex has been shown to have a deleterious effect on the physical health of the heart (Lowen, 1988).

On the positive side, substantial evidence now exists showing that good sex can boost the immune system, strengthen the heart, and reduce stress. Individuals who report having a satisfying sex life tend to be less anxious or depressed and to enjoy higher self-esteem than those who say their sex lives are lacking (Ornstein & Sobel, 1989).

The willingness to authentically investigate sexuality as a viable vehicle for conscious awareness opens up a whole new body-mind frontier for personal and relational exploration. This approach to sexual issues can be understood as a growth model, the philosophical base of Gestalt therapy.

A growth model incorporates both treatment and enhancement, but it is more than that. Self-discovery and the freeing of arrested development are the cornerstones of growth.

The Somatic-Experiential Model for Sex Concerns: A Comprehensive Body-Centered Gestalt Approach

A body-based Gestalt approach offers a progressive somatic-experiential model for working with sexual concerns.

We can move along a continuum from a problem perspective to a growth process, to an enrichment exercise, honoring the distinct value of each phase. In fact, we can work in all three areas simultaneously. Not only do we address deeper personal and interpersonal issues, but we can offer the client practical body-opening tools for shifting the focus in a sexual encounter from a successful performance to a pleasurable experience, and perhaps even to something truly transformative.

A somatic-experiential approach puts the body back into sex.

Whenever there are sexual issues of an inhibitory nature, the fear, shame, guilt, trauma, and negative thought patterns are all locked in the body in a defensive reaction to the possibility of sexual contact or interest. This is true regardless of the past events that instilled these feelings, or the current inner narratives that sustain them. Ultimately, it is the physical constriction that blocks contact. That means whenever such an individual encounters a potential sexual situation or begins to feel turned-on, he or she is likely to hold the breath and tense the body. The sensation of increased excitement often will trigger fear and tension rather than pleasure and letting go.

At the other end of the spectrum, some people overreact to their sexu-

al interest in a way that short-circuits the prospect of slowly building excitement to the fullest degree possible. These people seem to be in a rush to get it on, get it off, and get it over. As Clemmens (2000) observes, there can also be a "tendency to move from sensation to action, where feeling sexually attracted can lead to a pressure for immediate intimacy." The critical factors here become understanding the sense of urgency, practicing relaxation and containment of the excitement, and then learning to savor the feelings rather than aiming for immediate discharge.

Phenomenology is a keystone of the Gestalt model.

Phenomenology is a method of exploring the truth of one's present moment—what one can know right now—through observation of the phenomena of experience; for example, sensation, activation, thought, imagery. A core feature of phenomenological observation is to describe rather than explain what is encountered. The client is encouraged to articulate inner observations, as opposed to relying on old theories as to why things are the way they are.

By developing a phenomenological awareness of what occurs inside the body during the therapy session, clients can develop a clear sense of the deeper emotions that impact their sexuality. As they explore past sexual experiences and current encounters, their bodily sensations are often accompanied by spontaneous imagery. Memories of early sexual feelings, possibly traumatic incidents, and their interpretations of those experiences, become more vivid and can be re-experienced in a new, more creative way.

Moreover, as clients learn to identify even subtle sensations of emotions such as fear, shame, or anger during the session, they can transfer those skills to a sexual situation. They first learn to recognize emotional and sexual resistance and the inner dialogues that go along with them. They can then choose instead to take a few moments to breathe and relax, to connect with their partners if that is what they desire, and to be more present in the moment.

The creative experiment is an important method for accessing an individual's intrinsic resources.

By introducing a carefully designed activity, or a set of images, the therapist can assist a client to tune into the pleasurable, expansive sensations in their bodies, or to catch themselves as they tighten up. As Zinker (1977) has described it, "The experiment is the cornerstone of experiential learning. It transforms talking about into doing, stale reminiscing and theorizing into being fully here with all one's imagination, energy, and excitement."

Gestalt therapy is an existential therapy, founded on the principles of choice, responsibility (response ability), and meaningful living. Rather than maintain a fixed pattern of dissatisfaction and longing, individuals

can begin to experiment with new ways of doing things, expanding their daily horizons.

Pleasure counts.

Along with an awareness of the body in pain, another important aspect of a somatic-experiential model is to help people get in touch with the subjective experience of pleasure. How do they take pleasure in their lives? Is their body a source of pride and pleasure or of shame and discomfort? Have they introjected parental prejudices, dutifully renouncing their own joys? Do they force themselves to do what they hate in life, and then lose control and blow it all on a short list of guilty or self-destructive pleasures?

Or do they make time for simple everyday delights, recognizing that stopping to smell the roses energizes them and makes life more meaningful? What feels good? What works? These are the strengths that support and nurture growth, and contribute to what Zinker (2000) refers to as the "spirit of healing."

Clients also can begin to recognize how they may have mistrusted positive feelings in other areas in their lives. In particular, they can explore the phenomenology of their pleasures—embracing a wide spectrum of delights not only to enhance their sex lives, but also to deepen the emotional and spiritual bond with their mate and to enhance their sense of personal well-being (Resnick, 1994; 1997; 2001; 2002).

Practical Somatics: Breath and Body Awareness

Some clinicians believe that a somatic approach is synonymous with employing touch modalities in therapy. Skillful touching by a trained practitioner can certainly facilitate release.

But breathing exercises also encourage somatic awareness and energy release, and do so without the therapist's hands-on manipulation. For many individuals and couples who seek therapy for a sexual concern, being touched by the therapist may be experienced as intrusive and even invasive. This is particularly the case with individuals who have been sexually molested as children.

Touch is a primary boundary, and clients who do not know how to set boundaries, or whose boundaries have been breached, are prone to feeling violated. Moreover, for couples and individuals in a relationship, well-crafted homework assignments to do with one's partner can access the healing power of touch in a more private and intimate setting.

I do touch my clients, however, but not to instruct or release them. I hug them. Of course, some people walk straight out the door when the time is up and I will simply lay a hand on their back as they go. But for the huggers, no session is complete without that genuinely affectionate goodbye embrace. That is my touch therapy.

Breath work has some practical advantages.

Learning to use the breath as a tool for centering and checking in with one's heart and gut is not only helpful in therapy, but when practiced in daily life, enables a person to contact his or her inner subjective truth and set boundaries rooted in what feels right.

Shifting attention from the contents of their verbalizations to breath and body awareness also enables individuals and couples to make the switch from cognitive exploration to one based on present-centered processing and phenomenological observation. The consistent use of breath awareness methods is especially useful in drawing the connections between inner dialogues, attitudes, emotions, sensations, and holding patterns in the body.

Breath work starts with the therapist drawing the client's attention to his or her breath.

Breath awareness, at first, is *not* about changing any holding patterns, but merely observing and becoming aware of where the body is being held.

Then I demonstrate, and ask my clients to practice with me, three basic breath rhythms that may be used to facilitate emotional observation during therapy. In brief, the *cleansing breath* helps one relax and tune into the sensations in the body. The *releasing breath* helps to go deeper into those sensations, and the *charging breath* helps build more energy when excitation feels blocked (Resnick, 1997). After a minute or two of practice, these rhythms—utilized at various times to deepen process observations—become the facilitators of emotional and physical awareness.

Conscious breathing focuses attention on the natural bellows action of the torso, enabling greater attunement to where sensation and movement in the body are either stimulated or blocked. With an emphasis on the breath, men and women with sexual issues can become aware of feelings and imagery associated with their sexuality. They also become more aware of how their emotions and attitudes affect their bodies. When they talk about feeling guilt, shame, or fear, I ask them to point to the place in the body they feel that feeling, and to describe what it feels like. I encourage them to notice where they contract, where they feel expansive, and what imagery, memory, or thoughts are associated with these sensations.

In dealing with arousal issues, I draw the connection between the breath and passionate sex. Heavy breathing is the most arousing sound track for a sexually explicit movie. A person making an obscene phone call is known as a "breather." Focusing on where the breath is held during sex, and practicing breathing into tight areas to release the breaths can augment sexual excitement. It can also augment fear, shame, and other emotions, providing another kind of opportunity—perhaps not for sex, but for discovery and healing. All my homework assignments encourage clients to catch themselves breathing or holding the breath, and to practice a few moments of conscious deep breathing during any physical contact or sexual activity.

To demonstrate how I unite Gestalt and somatic awareness with a focus on sexual concerns, I will describe some examples of work with a couple. But before I do, I need to provide a little more of the theoretical underpinnings that prompt my therapeutic directions.

Couple Sex Therapy: Low Sexual Desire in a Committed Relationship

In my thirty years of specializing in relationship and sexual concerns, I have encountered a wide variety of presenting problems, including issues such as compulsive masturbation, sexual exploitation by a previous therapist, and marital infidelity. But I have been particularly interested in the potential for personal growth and fulfillment in successfully uniting love, commitment, and sexual desire. This is apparently not an easy task.

Recent studies confirm that low sexual desire in marriage is the most common sexual difficulty in America, and the most challenging to treat successfully in therapy (Weeks & Gambescia, 2002). There are many possible risk factors for losing sexual desire in long-term relationships.

Stress of all kinds is always a big factor in diminishing sexual appetite. Raising young children, job fatigue, and financial pressures can exhaust energy reserves.

There are also those couples in chronic conflict who harbor resentment, feel controlled, hurt, or wounded by the other, and who withdraw from one another sexually. Sex can become a major bargaining chip in a power struggle, particularly if one person seems to need sex more than the other.

Then there are the intergenerational patterns passed along from grandparent to parent to child. Clients with limited ability to sustain emotional and sexual intimacy acquired many of their ineffectual habits by watching parents in unhappy marriages, and then mechanically inflicted those same patterns on their own relationships (Schwartz, 2000; Teachworth, 2000; Zinker, 2000).

Some people come to us sexually injured, whether through out-and-out molestation or having been raised in a religious atmosphere that associated sexual desire with sin and damnation.

There can also be medical aspects involved in loss of sexual interest. Certain medications for blood pressure and antidepressants can have sexual side effects that limit libido. Hormone deficiencies also need to be ruled out as a factor through a thorough medical check-up.

Moreover, there is considerable evidence for gender differences in sexual desire, with male sexual desire typically more genitally focused, and female sexual desire more contextual. That means that sexual desire for women is more likely to be influenced by such factors as trust, comfort, and intimacy in the relationship (Leiblum & Rosen, 1988; Kaschak & Tiefer, 2002; Whipple, 2002).

Much of the work in couples therapy that deals with sexual concerns is based on talking through these issues and acquiring insight. While devel-

oping greater understanding into these complexities and building communication skills in dealing with them is essential, it is not sufficient. This approach simply does not go deep enough.

What makes individuals and couples deal with their stress by withdrawing from physical contact rather than seeking solace and replenishment through connection?

Do conflict and resentment inhibit sexual desire, or does inhibited desire foster conflict and resentment to deflect sexual contact?

What compels intimates to maintain a physical barrier despite the fact that both may genuinely wish it were otherwise?

Perhaps the answers lie in the likelihood that much of the closing-down mechanism is not accessible through words because the complex layers of internal constraint predate verbal ability and bypass verbal function.

Recent developmental research shows that the foundations for intimate attachment and the ability to share physical pleasure with a mate have emotional and psychological roots that are neurologically and biologically imprinted—they go back to our earliest, pre-verbal beginnings (Bowlby, 1969; Trevarthen, 1990; Schore, 1994; Sroufe, Carlson, Levy, & Engand, 1999; Main, 2000).

Moreover, in this culture, early sexual conditioning is fundamentally inhibitory. Children are not supposed to be sexual or even talk about sex. Sex-negative messages from significant adults were likely to have been non-verbal, conveyed tacitly in facial expressions, gestures, and in what was *not* said, or seen, or touched.

Once early attachment deficits are encoded in the brain and autonomic nervous system, and physical patterns of sexual inhibition are programmed into the musculature of the body, no amount of cognitive insight or talking it over is likely to be sufficient to release a longstanding physiological block. How can anyone talk about something for which they have no lexicon?

Moreover, before there can be truly gratifying sexual intimacy, there has to be a capacity for any intimacy to be truly gratifying. Sexual arousal depends completely on an ability to stay physically open as excitement builds, and is enhanced by positive emotional feeling. For many of the individuals who come for therapy, intimacy has never been fully nurturing, not when they were children, and not today. When excitement builds, so do their negative expectations and levels of tension.

Words certainly play a significant role in adult intimacy. We feel close to one another when we can share feelings and have a sense of being heard and understood. But the emotional and physical blocks that shut down people's energy also color their verbal communications and miscommunications. When these people feel hurt and become critical, shaming, passive aggressive, or withdrawn, there is, underneath it all, a heightened level of physical stress and sensations of fear, threat, and pain that need to be dealt with directly, not just vicariously through cognition.

Underlying Somatic Factors in Sexually Intimate Relationships

The following stand out for me as three critical somatic substrates that have been largely overlooked as risk factors, but have a major impact on the ability to maintain sexual desire in a loving and committed relationship. These are: 1) early attachment deficits, 2) incest transfer, and 3) pleasure-resistance.

1. The Connection Between Infant Attachment and Adult Intimacy

Inspired by the work of John Bowlby, Alan Schore has become one of the most prolific writers on the psychoneurobiology of attachment. Schore (1994, 2000) cites a plethora of evidence to show that infants have an extended period of brain growth after birth. Most significant, the research strongly suggests that ability to bond with another *as an adult* is wired into the central nervous system and the autonomic nervous system during early infancy.

During the first eighteen months of life, it is primarily the right brain of the infant that develops. The right cerebral hemisphere is associated with development of the ability to feel empathy, understand facial expressions, and read non-verbal communication. It is only during the second year of life that the left hemisphere begins to develop, and language becomes a factor.

Attachment always takes place in the context of the baby being held by a warm and intuitive caretaker, usually the mother. Smell, taste, and touch play a significant role. One of the most important interactions takes place through eye contact and in the spirit of play. At about eight weeks, the baby's intense gaze evokes the mother's gaze and vocalizations. If the mother allows the child to avert his or her gaze and is available with a direct gaze and an animated face when he or she returns, this brings delight to the child. If the mother is depressed, distracted, and expressionless when the child looks back, or if she is intrusive and demands eye contact when the child looks away, it causes distress in the child.

Studies show that the more the mother can allow the infant to disengage and waits for cues to re-engage, *the better the infant learns to self-regulate from a high state of sympathetic arousal (stress) to cycle down to a more relaxed state* (Schore, 2001a).

Autonomic balance is reflected by a state of quiet alertness. Individuals raised by either a chronically intrusive or a detached parent will have difficulty auto-regulating from high states of arousal, both negative and positive, to a more relaxed state. Individuals with poor attachment histories have been shown to have a limited capacity to deal effectively with stress and to perceive the emotional states of others. Their inability to read facial expressions often leads to a misinterpretation of the intentions of others.

According to Schore (1994), mutually synchronized interactions are

essential to the healthy development of the infant. The fact is, mutually synchronized interactions also appear to be essential to sexual intimacy between adults. Anthropologist Helen Fisher (1992) reports on cross-cultural studies which show that flirting behavior everywhere may start with idle chatter and progress to "accidental touching," but it is only at the point "that eyes lock and the two unwittingly begin to synchronize body movements" that erotic physical contact becomes almost inevitable.

This playful dance on a non-verbal, somatic level seems to be a basic movement sequence that accompanies, and may even stimulate, sexual arousal. Yet, many committed couples abandon playful, arousing flirtation in favor of a marital pattern of occasional sex which, when it occurs at all, is typically the last weary act of a long, exhausting day and a prelude to sleep.

Anthropological studies also indicate that gaze and gaze-avert patterns prior to erotic contact are universal across cultures (Hall, 1976; Eibl-Eibesfeldt, 1989; Givens, 1983; Perper, 1985). Moreover, the entire pattern of gazing into each other's eyes, disengaging, and re-engaging is a prototype of the contact/withdrawal interactions well known to Gestalt therapists as essential for good contact.

Recent evidence indicates that insecurely attached individuals can have adult experiences that enable them to become more secure and better able to cope with stress and positive affect (Main, 2000; Fonagy & Target, 1997). Schore (2001b) has outlined a plan of treatment based on a psychotherapist's ability to empathically resonate with a patient's body states, and to connect on an intuitive, non-verbal level.

Yet such "interactive repair" can take place not only with a therapist, but in particular with one's mate and physical intimate. Through body-oriented homework, the therapist can deputize intimate partners to create the kind of growth-facilitating environment that can help complete the interrupted developmental process for each other. Under such conditions, a truly intimate relationship can help each insecurely attached individual to form a secure and loving bond.

Deeply fulfilling physical contact, with its opportunities for warmth and holding, eye contact, smell, and taste can play a significant role in re-attuning partners to a sense of personal security and well-being. This kind of physical intimacy between two people is a necessary precursor to sexual intimacy.

2. Incest Transfer: Overgeneralization of the Incest Taboo

It has long been known that low sexual interest in a marriage is often specific to one's spouse, and not necessarily an indicator of a generalized low libido. According to the late psychiatrist and sex therapist Dr. Helen Singer Kaplan (1979), there are several clinical variants of hypoactive sexual desire (HSD). The most common of these is "situational HSD," an

inhibited desire for one's spouse while, at the same time, a strong sexual interest in uncommitted partners, unconventional sex, or strangers.

The observations of Belgian psychologist François Duyckaerts (1971) provide a key to understanding the underlying dynamics that inhibit sexual desire for an intimate. He points out that despite the strict social ban on incest, family members provide the first erotic stimuli of the developing child. At the same time, parents are likely to send inhibitory messages to the child in the form of avoiding physical contact, rejecting a kiss, or punishing any displays of sexual interest in the child, not only toward the parent, but toward siblings as well. As a result, *daily proximity itself,* for the sexually mature individual, may set off a block in the sexual cycle inhibiting sexual interest.

Research, especially on individuals raised on *kibbutzim* in Israel, has corroborated such observations, strongly suggesting that not infrequently, individuals develop a physical aversion to thoughts of sexual intimacy with anyone with whom they have grown up (Westermarck, 1934; Spiro, 1958; Shepher, 1983).

Thus, our earliest sexual foundation fosters a split between love and sex. This is a potent and largely unseen source of inhibiting sex arousal for one's mate: all the years of conditioning that desexualizes everyone in the family. Once under the same roof, the beloved becomes family, and there is a strong and primitive urge unconsciously to close down sexually with that person.

Incest transfer is the overgeneralization of incest avoidance in which the sexual shutdown originally conditioned toward a parent becomes associated with the mate. This is an especially compelling factor when the partners in the relationship have unfinished business with their own parents, which then feeds feelings of anger and resentment toward the mate. To make matters worse, when stress triggers conflict in the couple, it reactivates lifelong stuck patterns, and the first things to go are affectionate touch and playful physicality—gateway conduits for sexual interest and arousal.

3. Pleasure-Resistance

Wilhelm Reich (1942) was the first to recognize that one result of being punished as children for being too exuberant or displaying sexual interest is to learn to limit enjoyment of life's pleasures. As we begin to associate feelings of expansiveness with the pain of rejection, shame, or guilt, we learn to shut down by holding the breath, tensing muscles that would animate the impulse, and going numb. Any temptation that threatens to break through the armor arouses fear of losing control and a host of imagined disastrous consequences. As a result, individuals can actually come to fear pleasure. The more desirable the stimulus, the more the accompanying "pleasure-anxiety."

The resistance to pleasure manifests in a variety of ways. In a relationship, people with a high degree of pleasure-anxiety may feel vulnerable in response to a heightened state of positive arousal and act in a way that sabotages a partner's feelings of trust and closeness (Resnick, 1994).

In a sexual situation, people who resist pleasure can feel overwhelmed by their excitement, tense up, and dissociate from their body. Instead of being present and in contact with their partner, and with the sensations in their body, they seem to go into a trance, getting stuck in their heads, compulsively replaying negative mental tapes (Resnick, 1997).

In my view, pleasure-resistance is likely endemic in our society as a direct result of the cultural tendency to deny and punish infantile and childhood sexuality. Substantial evidence now exists to show that infants are sexual at birth, that toddlers enjoy stimulating their genitals, and that juvenile sex play is a natural developmental stage beginning in children as young as three or four years old. Yet, as a function of their own sexual suppression, many parents feel confused by, overreact to, and attempt to suppress their child's sexual interest (Martinson, 1994).

The myth of childhood sexual innocence means that many of us learned about sex between the ages of six and twelve from other six to twelve year-olds. The suppression of sexual speech, along with the subtle and often nonverbal sex-negative messages of significant adults, links guilt and shame with natural sexual development. Another undesirable outcome of learning to hide sexual activity, and defying sexual proscriptions during adolescence when arousal can be most intense, is that violating sexual taboos becomes part of the building blocks of adult eroticism. As a result, forbidden fruit tastes the sweetest, and it is possible to feel a fierce sexual desire for a complete stranger and have no interest whatsoever in the person one most loves and adores.

Now, let's look at an example of couples therapy initiated because of low sexual desire, and influenced by a wide assortment of risk factors. The somatic-experiential dimension was utilized as a parallel track to the cognitive exploration, serving to deepen observation and experimentation, and to enhance a variety of skills.

Despite the fact that this is a heterosexual couple, my clinical experience has shown that the same kind of interpersonal and somatic dynamics occurs with same-sex couples. Substantial research exists to show that, while gender-based sexuality differences naturally are less of a factor in long-term homosexual relationships, the same challenges that diminish libido among heterosexuals can erode sexual interest among homosexuals (Blumstein & Schwartz, 1983; McWirter & Mattison, 1984; Tripp, 1987). What is unique about same sex couples has more to do with what two men or two women bring to the relationship by virtue of their similar biology and acculturation. For example, both men in a couple may need help learning to express their needs, while the dynamics between two women

may foster fusion and confluence (Singer, 1994; Curtis, 1994).

Since homosexuals are exposed to the same infantile and childhood experiences that set them up for emotional vulnerabilities as adults, gay and lesbian couples share the identical capacity as heterosexual couples to heal one another's insecurities through warm, intuitive contact.

Couples Therapy: A Case Study

Joanne and Joe are a couple in their late forties who had not had any sexual contact for more than two years. They had been together for nine years—it was a second marriage for him and a third for her—and each blamed the other for their lack of physical connection. In the first session, they sat at opposite ends of the couch, with Joanne leaning on the armrest, her back toward Joe, and Joe facing me straight on as though he were pleading his case.

She said she had never been in a relationship with a man who showed so little interest in her sexually. She was certainly a stunning woman, and I could understand how that might be so. He nodded sheepishly and agreed that he did not seem to have a very high sex drive. In his defense, he could only say that she did not show much of an interest in him, either, and did not respond very enthusiastically when he did approach her.

Their family histories revealed tumultuous backgrounds, hers worse than his. She was born out of wedlock and never knew her father. Her mother had left her with her grandparents when Joanne was just a few months old, and there she stayed until her mother married when she was a toddler. As a child, she was sexually fondled on several occasions by her stepfather, and once by an older cousin. When Joanne finally got up the courage to tell her mother about the stepfather, the mother accused Joanne of trying to break up her marriage. Joanne's first husband was physically abusive, her second distant and critical. She had two children, a son and a daughter, whom she had twice left with her mother, once for over a year. They are now in their twenties, resentful, needy, and demanding. Joanne has been trying to make it up to them now for the mistakes she made as a young mother.

Joe hated his father who was a frustrated bureaucrat who took out his rage on his wife and two sons. Joe was the older son. He lived in terror of his father who had a terrible temper and who often ranted about the house when he was at home. Joe described his mother as damaged and constantly looking like a deer caught in the headlights. He said she was depressed most of her life and hard to reach, and that she never touched him. He disliked his brother who he felt was the favored child, and he reported that they still have no connection.

Joe said that he never had much of a sex drive, and had lost sexual interest in his first wife very early on. He thought things would be different with Joanne because they had a passionate relationship at first. But with-

in a year, their appetite for one another had dwindled to the point where it was now non-existent. They said they hadn't really kissed in almost two years.

It was obvious that neither Joe nor Joanne had known much genuine love in their early lives, that they craved love, and that neither was very skilled in giving or receiving it. Joanne said that she had dealt with the issues around her sex abuse in individual therapy and felt that she did not need to revisit it in our couples work. But we talked about how the lack of motherly love in both their lives left them touch-deprived, and how being touched inappropriately particularly complicated the issue for her.

We looked at how much stress each of them carried around on a daily basis, how difficult it was for each of them to de-stress at the end of the day, and how touch is one of the most natural ways for the human body to release tension. We talked about what little time their stressful lifestyle left for sensuous encounters. I suggested that they could help each other relax in the evening, and at the same time, provide the kind of nurturing necessary for healing the wounds of their childhood, by holding and stroking each other. We practiced some deep breathing exercises, and I gave them a homework assignment to lie together, to breathe deeply, and to take turns stroking one another.

Over the course of therapy, the focus of the work became the variety of ways, emotionally and physically, that they avoided genuine contact with each other, and how family of origin issues programmed them for lack of contactful interactions. We observed how they often talked to one another without looking into each other's eyes, and that when they did look at each other at my suggestion, they often snickered nervously and turned away. We explored how, when they talked, her impassive look and his frequent expression of exasperation were read by one another as "discounts" and created defensiveness in each of them.

Finally, after several months of progress, they came in one day in the middle of a quarrel and seemed to revert back to some of the disconnecting ways we had seen in early sessions. She was particularly agitated that they never made time for the cuddling exercise and that she still felt out of contact with him physically. I asked if they would be willing to do a touch exercise during the therapy session. They agreed.

During a previous session, Joe talked about how left out he felt by Joanne. Most nights, it seemed she would rather spend time on the phone with her children than be with him, and she could talk for hours on the phone with her daughter, giving her advice on her frequent crises. He said he never felt special with his mother and he never felt special with Joanne.

When I suggested they start the experiment by identifying the one sentence each needed to hear the most from the other, Joe immediately said that for him, it would be, "You are more special to me than anyone." She said that she could honestly say those words to him. He then suggested

that he knew what she most wanted to hear from him. When he said, "I'll always be there for you," she became visibly moved that he would spontaneously come up with the right sentence.

The exercise involved, first, that he put his head on her chest, and that she stroke him and say the sentence to him while they both breathed deeply. I left the room for five minutes and knocked before entering. When they called me in, he was weeping in her arms and she was stroking and rocking him. After talking about what had come up for both of them, we switched, and he held her as I left the room again. This time when I came back in the room, her eyes were softer than I had ever seen them. Even though it was only five minutes, she said it had been "a very lovely experience."

That session was a turning point for this couple in therapy. They began to include cuddling in their evenings several times a week, and we have explored other body-oriented experiments. Eye contact experiments were, at first, even more difficult for them to do without laughter, shyness, looking away, and hyper-reactivity. After two years of not kissing, we also did a session to break the kissing fast. First we talked about kissing. Then they practiced putting their lips together for three-minute, progressively more intimate intervals, with me leaving the room each time.

As the neuroscience has shown, maternally deprived children can grow up to be adults who lack the ability to ratchet down their level of stress. They are insecure because they have never been fully reassured in their fear, never fully comforted in their pain.

As a result of their early deficits, Joanne and Joe rarely approached one another for comforting. When they started therapy, it became obvious that any irritation or anxiety that was aroused while they were apart tended to provoke conflict between them, and they would avoid one another rather than seek physical contact. What this couple now comprehends is that their lack of physical connection was not just a reflection of, but a major contributing factor to, their emotional detachment.

Nor did they permit themselves much release. Over the course of our work, there were numerous opportunities to identify pleasure-resistance in each of them. At the office, Joe seemed to have an attitude that if he was not tense and uptight, he was not working hard enough. Joanne rarely left time in her busy schedule to take breaks just for herself. She said she had no patience for getting a massage and, although she said she enjoyed hot baths, she rarely allowed herself the luxury of one. Clearly, Joanne and Joe's paucity of physical intimacy was more profound than merely the lack of sexual intercourse.

Body-Based Intimacy

The word "intimacy" comes from the Latin *intimare*, meaning "to press into, to make known." The same factors that allow us to press into and

make ourselves known on a verbal level also operate on a nonverbal somatic level, allowing us to press inward and discover ourselves more deeply where words can fail. Three attributes of intimacy from a Gestalt perspective are particularly enhanced by a greater awareness of the somatic dimension in the relationship.

An intimate experience can be understood phenomenologically *as discovering oneself in the presence of the empathic other.*

As Wheeler (1994) describes it, "intimacy is a mutual process of knowing and co-creating another's personal ground and of making one's own ground available and known." Soft gazes, lingering eye contact, a smile, a nod, a hand on the other's shoulder, all encourage that kind of fully-present availability.

Intimacy is intersubjective, *two people in contact, emotionally attuned, and co-constructing their reality.*

In the words of Martin Buber (1958), existential philosopher and early intersubjective theorist, each individual "bodies forth" the other. Whether one evokes the loving-other or the withdrawn-other often depends more on non-verbal cues than on words. Much of intersubjective relatedness is communicated through the body in the tone of voice, facial expressions, and gestures. In fact, an emphasis on language can actually render some aspects of internal experience less accessible to sharing (Solomon, 1992; Sapriel, 1998; Zinker, & Cardoso-Zinker, 2001). If words and body language contradict one another, we always believe what is conveyed in the nonverbal message.

Fundamentally, intimacy is teamwork.

To be an effective team, to support one another's growth, as well as to accomplish domestic goals, takes two people who are different rather than confluent. As Melnick & Nevis (1994) point out, a balance of power enables a long-term, intimate relationship to flourish. But though two people in a couple need to be equal *in* everything, they are not necessarily equal *at* everything.

A truly nurturing intimacy has the capacity to help each individual heal from the pain of the past, and to empower each one of them, in the present, to reach for their dreams. Research on the effect of early attachment history on adult intimacy has shown that within five years, an insecure partner can develop a solid sense of security by having a secure mate (Main, 2000). Moreover, there is evidence to suggest that the ability to overcome feelings of long-term, internalized shame also hinges on developing security in current relationships (Lee, 1994).

When two people have the will to go deeper with one another, not only confronting their pain, but actively participating in their pleasure, noth-

ing feels impossible. The whole is truly more than the sum of its parts.

Joe and Joanne's ability to be intimate was enhanced by a parallel focus on both their verbal communication and their physical connection. Touching and breathing together has re-sensitized their anesthetized skin and nurtured and energized them. With their relationship on the line, and strong motivation to help heal one another from the arrested development of their earliest experiences, Joanne and Joe were willing to break through their resistance patterns.

Because of their early histories, Joanne and Joe have never had any adequate means for self-regulating their stress. Feeling more nourished and less stressed as a result of how they are now treating one another has created the good will that fosters being attentive and less defensive on a cognitive level. Now when they communicate more positively, it is not just because they are "playing by the rules" and doing what they are supposed to, but because they really do feel more grateful and more generous toward the other. This self-reinforcing loop of positive feelings and actions has laid the foundation for a more vital physical and emotional relationship.

Sexual Intimacy

Joanne and Joe's sexual intimacy, however, has not progressed to the same degree as their physical intimacy. Several months ago, Joanne angrily disclosed that she knew that Joe had visited several pornographic sites on his computer. Joe's reluctant admission that he was indeed watching porn and masturbating exposed the fact that his sex drive was intact—just not directed at Joanne.

As we looked more closely into the erotic aspects of their relationship, we discovered that there were none. Joe said he couldn't shake the feeling that making love with Joanne "just wouldn't be right." He reiterated, as he had on numerous occasions, what a good mother she is and how much he admired her. He also said he felt no inspiration to approach Joanne, and he bemoaned the fact that she always undresses for bed in another room and hides her beautiful breasts from his view. Joanne had countered that she hides from Joe's view when she undresses because he had rejected her advances so many times, she did not feel like parading her body before him.

Joe also revealed that oral sex was always an important part of his sexuality, and that Joanne does not like it. He has been clear that he has too much respect for her to impose it upon her. While Joanne has indicated she does not want this kind of "respect," becoming more open to a variety of sexual activities does present a challenge for her.

On several occasions, we looked at the clear evidence for differences between male and female sexuality and how they are each a reflection of these differences. We addressed men's responsiveness to visual stimulation, and women's fondness for sweet talk and affection. Whether these

differences are inborn or cultural, the important factor is that they do exist and need to be addressed rather than criticized. For example, masturbating to pornography often plays a leading role in male sex development, while it is almost non-existent in early female sexuality. Some females have had to become familiar with their genitals as adults and to develop skill in self-pleasuring before they could become orgasmic (Zilbergeld, 1981; Barbach, 1975; Dodson, 1987).

In the most recent session, we discussed the importance of erotic play in making the shift from a non-sexual situation to one that inspires some sexual interest. At first, Joanne recoiled at the notion of being sexually flirtatious and said it felt phony. She knew that if she and Joe tried it, they would only laugh. I said I thought laughter would be terrific and could signal the beginning of some real enthusiasm between them. They have both agreed to push their sexual envelope a bit more.

This is where we are to date. Joanne and Joe have become more physically affectionate and more secure in their bond. They hug each other and kiss. They look into one another's eyes when they talk. As they each feel safer and more loved on a physical level, they are more relaxed. She is far less willing to take grief from her children, and they are spending more evenings after work at home to decompress and spend quiet time together. Rather than turn the tensions of the day into bickering and being irritable with one another, they help each other to de-stress. They now can enjoy their unspoken connection, the intersubjective level of their communication.

Their verbal communications have also become direct to the point where we have opened up a genuine dialogue about sex—a courageous dialogue in which their differences are being honored rather than discounted.

I report this as a work in progress despite the fact that Joe and Joanne are still not engaging in sexual contact. Other couples I have seen have presented less of a challenge. In one couple, the husband had a strong desire for sexual contact, and he played a supportive role in helping his wife past her sexual shame and low tolerance for pleasure. Another man came to see that as soon as he committed to a woman, she became his "best friend," just like his mother, and he no longer desired her. His determination moved him from a tacit expectation that an open-heart-requires-a-closed-pelvis to a more erotic physicality with his own wife. His willing wife said that in the process, she discovered erotic talents she did not know she had. On the other hand, when both individuals have sexual issues that dovetail, as do Joanne and Joe, it is much more difficult for each to support the other's growth.

At this point, we are working effectively as a team to re-awaken a long-dormant sexuality. We are all optimistic.

Some Key Principles for Somatic-Experiential Sex Therapy

What I have described is a comprehensive approach to sex therapy that operates in all modalities: somatic, experiential, cognitive, behavioral, and in its emphasis on silent attunement, spiritual. The following are some key aspects of a body-based Gestalt therapy that guide my work with clients with sexual issues:

1. *Breath and Body Awareness.* Focusing attention on breath and internal experience changes the pace and depth of the investigation. By shuttling between cognitive exploration and moment-by-moment processing, we can shift from a left-brain to a right-brain atmosphere. Breath work helps access and intensify emotions, sensations, and imagery. I make the distinction for clients between the need to release tension and reduce energy blocks versus the need to contain energy in order to sustain higher levels of positive arousal. This way of working supports individuals to reconnect with inner subjective truths and authentic pleasures.

2. *Sexual Focus.* I consider it essential to honor the sexual distress, and to give sound sex information when appropriate. The key is to reframe what may feel like a relational disaster into a positive learning opportunity. I distinguish among emotional, physical, and sexual intimacy, and how each augments the couple's connection. I encourage breath and body awareness during physical and sexual contact, and in both solitary and partnered sexual experiences.

3. *Relationship Focus.* I always take a thorough family history and trace with clients the associations between present issues and the past, especially with respect to the continuing effects of parental deprivation or unresolved trauma. If the client is a couple, I encourage them to become a bodywork unit—helping to heal one another's past wounds as well as enhance non-verbal communication skills.

4. *Experimental Focus.* Creative experiments within the therapy session and for homework are essential. Clients' observations, irrespective of their ability to complete the experiment, become valuable resources for gaining insight and courage. Zinker (2000) relates that one element in the "unit of work" outlined by him and Sonia Nevis in working with couples has to do with "constructing an experiment for the couple that has the potential to strengthen the undeveloped parts of the system." Some of the most potent experiments can be those that aim to strengthen the physical bond, of which sexuality is one important part.

In summary, this paper has explored a body-centered, Gestalt approach

to one of the most common sex-related disappointments we are likely to encounter in our work with couples: the frustrating lack of sexual desire for one's mate. I have delved into some of the inhibition that is programmed into the body as a result of deficits in early family experiences, and the effects of sex-negative and pleasure-negative childrearing. I have also explored some methods for working experientially with clients to help them make up for these deficits and evolve a more loving connection by enhancing their physical and sexual bond.

Ernest Becker (1973) tells us that "…one of the first things a child has to do is to learn to abandon ecstasy, to do without awe…" so that he can act as though he can control his life and his death. He tells us that "by the time we leave childhood we have repressed our vision of the primary miraculousness of creation."

Physical affection between two loving human beings who are committed to one another, combined with emotional and sexual intimacy, is one of life's grand opportunities to reconnect with that sense of the miraculous.

EPILOGUE

After a year and a half of therapy, Joanne and Joe did regain their sexual relationship. They were in bed one night reading when Joanne, feeling "a little turned-on," impulsively turned toward Joe and began to kiss and caress him. To their surprise, he responded with genuine excitement and she felt even more turned-on. When they reported the incident in therapy, they were all smiles and giggles—almost shy. Since that time, they have been like teenagers, rediscovering their sexuality in a way that is different from anything either had known before. Joe said it best. "It's so simple now," he shrugged. "I love Joanne and I love her body and I love being close to her. It's not as complicated as I thought." Broad smile from Joanne.

They have each made their own breakthroughs, but they helped one another to make them. Bare bones, what has all their work amounted to? On a deep level—a somatic level—he learned to relax and to trust *good*-feeling love, and she gave up a defeated, resentful passivity and lightened up. It has made all the difference in their sex life.

I still see them in therapy, but not as often.

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