

Mindfulness: An Effective Therapeutic Approach for Female Clients
Presenting with Anxiety-Related Sexual Pain

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Abstract

In a culture brimming with photoshopped imagery and pornographic videos, sexual anxiety is prevalent. The failure to live up to perfectionistic body types and imitations of unrealistic sexual encounters leaves many overwhelmed. For the female population, this sexual anxiety is frequently interwoven with sexual pain. The recurrent reports of anxiety-related sexual pain surfacing from medical and psychological professions have led to the diagnosis and publication of this disorder by the American Psychiatric Association. The DSM 5 classifies this sexual dysfunction as genito-pelvic pain/penetration disorder.

The review of existing literature highlights limitations in the traditional methods of treatment. These methods fail to recognise the emotional and cultural factors at the source of anxiety-related sexual pain. As the studies suggest, this dysfunction is often triggered by cognitive distortions. With this in mind, this thesis advocates a compassionate therapeutic approach, as this may prove more valuable than the customary medical and physical styles of treatment.

Due to a surge in popularity alongside enthusiastic scientific and theoretical supports, this study examines mindfulness as a beneficial approach when treating this particular sexual dysfunction in a psychotherapeutic setting. Mindfulness advocates a safe, non-judgmental, accepting attitude grounded in the present moment, inciting the belief that a sexual connection with oneself or one's partner can be enhanced. Throughout this thesis, the various empirical and theoretical findings substantiate the argument in favour of mindfulness as a useful practice for women suffering with anxiety-related sexual pain.

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Introduction

“The behaviour of a human being in sexual matters is often a prototype for the whole of his other modes of reaction in life” - Sigmund Freud, Sexuality and the Psychology of Love

Although Freud was not always correct in his interpretations, he opened up a space for the link between psychological symptoms and our sexual experiences to be explored. Freud's contributions inspired the psychological world to acknowledge the impact of sociological influences on one's sexual well-being (Berry, 2012, p.59). Having acknowledged the connection between our psyche and our sexuality, the therapy room became a place where it was acceptable and helpful to explore one's sexual fantasies (Friedman & Downey, 2000, pp.567-568).

In recent years, third wave feminism has empowered women to speak candidly about their sexuality and sexual desires. This contemporary era of feminism promotes women's rights to explore and experiment with their sexuality. Now more than ever, women are progressively liberating themselves from the stigma surrounding female sexual expression. Yet, even in the face of progress, guilt and shame continue to contaminate the minds of many. For that reason, it may be valuable to address the underlying repression of desire that women continue to experience and the damaging effect this has on their sexual understanding (Williams & Jovanovic, 2014, p.158). Although this new era has inspired growth, potentially obstructive advancements have also surfaced. On the one hand, the Internet provides a valuable platform for women to openly discuss their sexual choices and desires. On the other hand, however, this platform has become saturated with idealistic, sexually charged images and pornography.

This consistent shower of videos and images of the 'perfect' body and unrealistic sexual experiences can be overwhelming. While many people understand these productions as a model of entertainment, many others find it difficult to separate the novelties from reality and, as a result, feel pressured to reach unattainable expectations. A review of the literature suggests people tend to over-analyse their sexual experiences in response to these expectations. These critiques become a source of guilt, shame, and a sense of inadequacy. In addition, these negative thoughts are likely to occur before and during sex, thus disrupting the connection between themselves and their partner and preventing them from enjoying the physical act itself. (Peloquin, Bigras, Brassard, Godbout, 2014, p.180).

Third wave feminism strives to cultivate a positive message of sexual pleasure and sexual agency in the lives of women today. Although women are now educated on their sexual health, their own sexual exploration and desires are less considered. Many women still feel guilt and shame in response to their lust and desire. This has a damaging impact on their sexual choices and encounters (Williams & Jovanovic, 2014, p.160). Guilt and shame foster anxiety in a world where women feel pressured to remain secretive about their sexuality. Regrettably, in an attempt to escape from these anxious feelings, the anxiety often intensifies. As a result, an appreciation for the present moment can prove very difficult throughout a sexual experience (Kimmes, Mallory, Cameron, Kose, 2015, pp.286-287).

This thesis promotes mindfulness as an effective therapeutic approach for women struggling to remain present within their sexual practice. Mindfulness nurtures a non-judgmental understanding of one's sexual encounters and has therefore proved useful in treating a range of sexual dysfunctions, from arousal to pain, in both men and women (Kimmes et al., 2015,

p.287).

Definition of Sexual Anxiety

“Sexual anxiety is defined as the tendency to experience tension, discomfort, and anxiety about the sexual aspects of one’s life” (Brassard, Dupuy, Bergeron, Shaver, 2015, p.112).

Definition of Sexual Pain

Pain is seen to be a leading component of sexual anxiety. Sexual anxiety and sexual pain are often recognized as interlinked and in the past the disorder was divided between two diagnoses: dyspareunia and vaginismus. In essence, they both referred to the experience of either pain or discomfort during sex *or* the inability to be penetrated as a reaction to the fear of pain (Rosenbaum, 2013, p.20). Both disorders inferred a painful reaction from the pelvic floor during penetration in response to sexual anxiety (Rosenbaum, 2013, p.21). In recent years the American Psychiatric association has combined the two disorders under the heading “Genito-Pelvic Pain/Penetration Disorder”. The DSM 5 changed this section of sexual dysfunctions in order to unify the previous 2 disorders, as there was great difficulty in telling them apart (Bergeron, Munt, Aerts, Rancourt, Rosen, 2015, p.160).

According to the American Psychiatric Association, the following criteria indicate Genito-Pelvic Pain Penetration Disorder:

A. Persistent or recurrent difficulties with one (or more) of the following:

1. Vaginal Penetration during intercourse.
2. Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts.

3. Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration.
 4. Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.
- B.** The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- C.** The symptoms in Criterion A cause clinically significant distress in the individual.
- D.** The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition (American Psychiatric Association, 2013, p.437).

As stated above, to be diagnosed with genito-pelvic pain/penetration disorder one must show signs of frequent difficulty with the above symptoms for a period of 6 months or more (Bergeron et al., 2015, p.160). Research has shown that women experiencing sexual-pain disorders report a piercing or stinging pain when the area around their vaginal and urethral regions is touched (Meston & Bradford, 2007, p.248). Now and then sexual pain disorders can be attached to a sexual arousal disorder. In these cases, the vagina does not become sufficiently lubricated for penetration. This can result in resistance, rubbing and tearing, causing significant pain. It is believed by some that “reduced sexual arousal and fear of pain are thought to become conditioned responses to sexual situations” (Meston & Bradford, 2007, p.249).

Sexual pain disorders can often be compared to chronic pain disorders as both seem to show psychological responses intensifying physiological sensations (Meston & Bradford, 2007, p.248). Considerable levels of anxiety have been found amongst women experiencing these forms of sexual pain (Corretti & Baldi, 2007). However, this does not mean that all women who experience sexual anxiety also experience sexual pain. Nevertheless, research indicates anxiety as a prominent component in upholding sexual pain (Meston & Bradford, 2007, p.248).

Objectives of Thesis

The objective of this thesis is to generate an understanding of sexual anxiety-related pain and the anguish it causes to women suffering from it. Through studying the signs and causes of anxiety-related sexual pain, an appropriate model of treatment will be explored. In this case: mindfulness will be looked at as an effective psychotherapeutic approach to alleviate or minimise the distress brought about by sexual anxiety.

Composition

This thesis will take the form of a literary review, comprising of three core chapters. The information discussed is sourced from current theoretical and academic literature. Contemporary journal articles were obtained from online databases. Books published, which are relevant to the themes in this thesis, are also considered and applied to the study. This thesis benefits from both historical and present-day material, as this subject matter is an ongoing area of interest. The author of this thesis strives to prioritise the facts of the current literature and studies and avoid amending this information to suit her own personal bias.

Chapter one outlines the possible contributions towards the development of an anxiety-related sexual pain disorder together with a study of the traditional methods of intervention and the potential limitations of these methods. Chapter two explores mindfulness ideals and the benefits of its practice, focusing on the features relevant to anxiety-related sexual pain. The final chapter will focus on mindfulness as an applicable therapy style when working with women suffering with anxiety-related sexual pain.

Chapter 1

What is Anxiety-Related Sexual Pain and what are the Causes?

“I am two women: one wants to have all the joy, passion and adventure that life can give me. The other wants to be a slave to the routine, to family, to life, to the things that can be planned and achieved. I’m a housewife and a prostitute both of us living in the same body and doing battle with each other” - Paulo Coelho, Eleven Minutes

This chapter investigates two questions: what is anxiety-related sexual pain and what causes women to develop this sexual dysfunction? This will involve reflection upon the prevalence of this dysfunction and the significant effect it has on a woman’s emotional well-being. The sources of sexual anxiety will be considered, emphasising the influence of emotional reasoning. The current modes of rehabilitation known to the author will be deliberated, highlighting limitations and the need for a compassionate therapeutic approach.

Prevalence

“Female sexual pain disorders are prevalent and have a deleterious effect on women’s well-being” (LoFrisco, 2011, p.573). The exact prevalence of genito-pelvic pain/penetration disorder is currently not known (American Psychiatric Association, 2013, p. 438). In recent years it has been reported that “up to 21% of women between 18 and 29 report pain during intercourse” (Davis & Reissing, 2007, p.245). Olga Sutherland reported that an investigation carried out in 2006 by Paik and Launman researched over 15 different studies of women in the U.S. to find “5–22% for problems with sexual desire, 4–14% for sexual arousal, 5–16% for orgasm problems, and 7–19% for painful sex” (Sutherland, 2012, p.224). More recently it

has been found that sexual pain affects “14 to 34% of younger women and 6.5 to 45% of older women” (Bergeron et al., 2015 p.159). It can be quite difficult to identify genito-pelvic pain/penetration disorder, often taking three or more different doctors to establish a diagnosis (Brotto, Basson, Smith, Driscoll, Sadownik, 2015, p.417). On top of the widespread reports of female sexual dysfunctions, women now appear to suffer more acute and long-lasting types of sexual complications than previous generations (Sutherland, 2012, p.224).

Sexual anxiety can be heavily destructive towards a woman’s mental health for many reasons. First of all, it can greatly influence her level of sexual satisfaction, resulting in little or no pleasure, conceivably causing her pain and discomfort. Secondly, if in a relationship, it can cause a lot of stress, tension and even feelings of guilt between herself and her partner. The woman may believe she is a failure, self-criticising as she feels she is not meeting the sexual expectations of her partner and herself. Thirdly, it can shape her overall well-being, possibly causing her to feel defective or abnormal (Rosenbaum, 2013, pp.20-28). Women with sexual pain admit to struggling with arousal and orgasm and, as a result, show a decrease in the active desire to participate in sexual intercourse (Bergeron et al., 2015, p.163). Sexual fulfillment can contribute to a woman’s general well-being. If a woman has regular, positive sexual experiences, her overall happiness is enhanced. However, women suffering from sexual anxiety may experience little or no satisfaction. For that reason, there may be a significant negative effect on their overall mental health (LoFrisco, 2011, pp.573-574).

Nowadays one’s sexuality and sexual desires are no longer unacceptable topics of conversation. The outdated ideas that sexual dysfunctions were solely physical or defective matters have increasingly transformed to be viewed as workable customary issues. The

stigma surrounding sexual dysfunction seems to be diminishing within modern day society, allowing for a more open discussion and psycho-therapeutic involvement. Sexual satisfaction is now viewed as an important part of each person's well-being, alongside their overall physical and emotional health. Most people hope to enjoy a happy and pleasurable sex life and are now less embarrassed discussing the ups and downs with friends and professionals. However, there is still a lot of work to be done when it comes to finding appropriate treatment and separating old-fashioned methods for more up-to-date alternatives (Leiblum, 2007, p.4). Nonetheless, some positive changes have taken place, including an increase in the number of people choosing individual or couples counselling to manage their sex life as opposed to the once preferable medical treatments (Leiblum, 2007, p.12).

Anxiety can be described as a sense of uneasiness or nervousness and dread indicated by symptoms of various cognitive, bodily, and emotional responses. Feelings of anxiety surrounding sex can spoil sexual excitement as one's attention is diverted from the sensual stimulations occurring (Corretti & Baldi, 2007, p.1). Hence, it is highly possible the tension in the pelvic floor during sex is directly related to the woman's frame of mind at that moment (Rosenbaum, 2013, p.21). "Elevated rates of comorbid anxiety disorders and higher trait anxiety have been found across subtypes of sexual pain disorders" (Meston & Bradford, 2007, p.248). Substantial levels of anxiety have been found in women suffering from sexual pain disorders and some interesting theories focus on the woman physically responding to sexual stimuli as a threat, thus subconsciously tensing the pelvic floor to protect herself (Corretti & Baldi, 2007, p.1).

Causes

There are a variety of studies that suggest sexual pain is possibly triggered by “negative sexual attitudes, religious orthodoxy, lack of sexual education, traumatic sexual events” or “childhood sexual abuse” (Binik, Bergeron, Khalife, 2007, p.131). Studies have shown that women who feel sad, guilty and other similar emotions during sex show a much lower level of pleasure and satisfaction than women experiencing positive thoughts (Oliveira & Nobre, 2013, p.437). It is also important to note this reaction may not solely be related to anxiety based on sex itself. In fact, many women with sexual pain do have sexual urges, arousal and orgasm when participating in non-penetrative activities. In addition, some women also experience this pain when carrying out other penetrative experiences that do not involve sex e.g. inserting a tampon. This would add to the theory that in some cases it is the fear of pain itself that can cause bodily tension for women. (Rosenbaum, 2013, p.21).

Cause: Medical Illness

Genital pain during penetration could be the result of various medical disorders (e.g. urinary tract infection, endometriosis, uterine fibroids) and it is recommended that any medical causes should be ruled out before a therapeutic intervention takes place (Meston & Bradford, 2007, p.248). Medical stresses early on in adult life such as fatigue and irritable bowel syndrome are a likely contribution to this type of anxiety/pain (Brotto, Basson, Smith, Driscoll, Sadownik, 2015, p.417).

Cause: Sexual Abuse

It is possible but certainly not definite that someone experiencing sexual pain may have survived a sexual trauma in the past. A variety of sexual complications have been connected

with adults who have been mistreated as children, particularly those who have been sexually abused. These complications involve feeling tormented or upset during sex and diminished sexual enjoyment (Bigras, Godbout, Briere, 2015, p.465). Memories of abuse can surface before, during or after a sexual experience, activating past similar physical and emotional responses. This would understandably result in many unpleasant sensations (Kocis & Newbury-Helps, 2016, p.691). “Higher catastrophizing, fear of pain, hypervigilance and lower self-efficacy have been associated with increased intercourse pain intensity” (Rosenbaum, 2013, p.21).

Cause: Religious Orthodoxy

One’s sexual outlook can be heavily swayed by strict religious belief systems. Being brought up within set cultural ideals can influence one’s gender, sexuality and behaviour i.e. what behaviour is appropriate within this religion and what is not (Bhavsar & Bhugra, 2013, p.144). For example, genito-pelvic pain/penetration disorder is commonly reported in Turkey, which comprises of a majority muslim population. However, there is not a substantial amount of research done on this particular origin (American Psychiatric Association, 2013, p.437).

Cause: Low Self-Esteem

Sexual self-esteem is said to be a huge factor in sexual anxiety. “Sexual self-esteem includes positive regard for and confidence in one’s capacity to experience sexuality in a satisfying way” (Bergeron et al., 2015, p.112). Anxiety surrounding sex can often be initiated by a fear of not meeting one’s partner’s sexual expectations, or a belief you are not good enough to sexually please another person. Essentially, it is anxiety around being judged by another person. A link between social phobia and sexual pain disorders has been determined (Corretti

& Baldi, 2007, pp.1-2). Depression, anger and psychosis have also been erratically reported (Meston & Bradford, 2007, p.249).

Alongside a negative body image, insecurities regarding genitalia and sexual performance are found to contribute to sexual anxiety. (Dunkley, Goldsmith, Gorzalka, 2015, p.92). Low sexual self-esteem is seen to be directly connected to a lack sexual enjoyment and an increase in discomfort (Bergeron et al., 2015, p.112). Sexual dysfunctions are commonly reported amongst people who experience self-doubt surrounding their body image or performance during intercourse when compared with people who are less distracted by unhelpful critical thoughts (Dunkley et al., 2015, p.92). Research indicates both men and women with poor body image tend to suffer with low sexual self-esteem and, for that reason, many actively avoid sexual experiences. Someone with a poor body image may feel preoccupied and insecure about their size or shape, disturbing the sexual experience. Being subjected to an array of the media's unrealistic beauty standards on a daily basis, various issues can crop up. These false images may generate feelings of despair as they intrude upon real-life relationships (Buss, 2003, p.65). Considering a large amount of people are affected by these images on one level or another, this is a cause for concern. Laing claims this has generated an assortment of sexual difficulties, primarily causing people to worry about their sexual capabilities. A lack of bodily confidence may well impact sexual intimacy as one might not be comfortable exposing their body. In this case, they may not trust their partner to accept them for who they truly are. Seeing your body as something to be ashamed of could prevent the relaxed attitude that is quite possibly needed for sexual stimulation. Once again, the connection between the two people suffers and the intimacy can be damaged (Laing, 2002, p.100).

Cause: Attachment Insecurities

Bearing in mind that a sexual partner can mirror a caregiver, many people suffering from attachment issues may also experience sexual pain disorders. The level of physical and sometimes emotional closeness during sexual intercourse sparks and continues an attachment bond. Sex can also be a way in which to fulfill one's attachment desires such as "feelings of safety, reducing anxiety, boosting self-esteem" (Brassard et al., 2015, p.111). Considering this, attachment insecurities could interfere with a person's sexual satisfaction. A person may have a distorted view of themselves, their sexuality and their sexual encounters caused by "low sexual self-esteem, sexual anxiety, and lack of communication with one's partner" as a result of their attachment issues (Brassard et al., 2015, p.112).

A childhood experience with problematic attachment figures could easily lead to troublesome trust issues. The person may either fear rejection, believing that they are not worthy of love, or they might view their sexual partner in a negative light, doubting their ability to support or comfort them. These types of damaging assumptions can create a barrier in the relationship, preventing the development of both emotional and sexual intimacy. The "coordination of both partners' attachment and caregiving behaviours is an accessory to the couple's optimal adjustment and happiness" (Peloquin, Bigras, Brassard, Godbout, 2014, p.179). Instead of enjoying sexual experiences with their partner, someone with attachment insecurity may use sex as a tool to gain approval and avoid rejection. They might prefer masturbation so they don't have to emotionally connect during sex. It is also possible they dislike sex altogether, finding it difficult to be aroused. "Sexual satisfaction and overall sexual functioning are already known to be related to attachment dispositions" (Peloquin, et al., 2014, p.179).

While there is no evident solitary reason for anxiety-related sexual pain in women, one reasonably common connection reported is the feeling of one's sexual stimulation and desire being detached from their body's physical reaction (Brotto, 2013, p.64). Overall, it appears to be emotional rather than medical difficulties that trigger this sexual dysfunction. Most commonly these emotional stressors include "self-dislike, hypervigilance and somatic preoccupation, perfectionism, somatization, fear of negative evaluation" (Brotto, Basson, Smith, Driscoll, Sadownik, 2015, p. 418). Such emotional stressors are known to cause sexual pain, as stress is known to disrupt the central nervous system which heightens the body's reaction to touch i.e. It becomes more painful. Therefore, a woman's sensitivity to genital pain increases due to the changes in her neuro-system. As you will see later in this study, Mindfulness is an applicable approach to helping clients manage sexual pain as it disengages the connection between the physical and emotional response to pain (Brotto, 2013, p.66).

Current Approaches

In the past, women experiencing these disorders were treated medically. However, now the psychological, sociological and relational factors are far more considered. The emotional contributions to the mechanical reactions are now far more relevant than the physical responses (Oliveira & Nobre, 2013, p.437). The sexual dysfunction itself can be seen as secondary to the emotional issues that result in the physical response (Binik et al., 2007, p.125). Many treatments have been tried and tested to treat anxiety-related sexual pain including "topical creams, oral medications, biofeedback, physical therapy, cognitive-behavioral sex and pain management therapies, specific pain management techniques such as nerve blocks, acupuncture, and hypnosis, surgery, and numerous

complementary or alternative therapies including diet and herbal remedies” (Heiman, 2007, p.133).

Because sexual pain disorders are not purely a physical disorder and are a response to psychological stress, traditional methods of treating them have been found ineffective at times and occasionally they cause more damage. Many conventional methods fail to recognise emotional and sociological differences. The idea that a woman must achieve penetration to be considered “normal” by society can cause even more psychological stress and each time this result is not achieved she can feel like a failure, developing a sense of abnormality, lowering her self-esteem and increasing anxiety. As a result, the physical symptoms continue (Rosenbaum, 2013, pp. 22-23).

Current Approaches: Physical Therapy

One of these traditional methods is pelvic floor physical therapy. This form of therapy aims to “normalize and reduce pelvic floor muscle tone” (Rosenbaum, 2013, p.21). With this physical form of therapy, the woman is internally examined. This type of treatment potentially sparks emotional distress. Consequently, the patient may dissociate during the exam in order to accommodate the medical practitioner. This type of behaviour may mirror what happens during intercourse with her partner and therefore the cycle continues (Rosenbaum, 2013, p.22). Leiblum reports that both gynecological practitioners and their clients have indicated these examinations were traumatic at times (Heiman, 2007, p.135). Since the patient is already apprehensive when anticipating penile penetration, a physical exam will create the same sense of fear thus causing great physical anxiety. This nervousness triggers tension within the body and of course, the pelvic floor (Heiman, 2007, p.135). “This

is further complicated by sociological and cultural expectations of intercourse as an inherent aspect of the sexual relationship and the burden of responsibility and guilt already being carried by the female partner for not “providing sex” (Rosenbaum, 2013, p.23). The woman resists any pain and discomfort in order to participate in penetration and satisfy the other party despite her own well-being. The guilt they hold over not being able to adequately provide a positive sexual experience for their partner causes the woman to view their sexual pain as something they must overcome. This fear of failure with penetration only increases the anxiety each time a sexual or penetrative encounter arises. Instead of the treatment focusing on the woman’s thoughts, emotions, pleasure and connection, the treatment purely sets the goal of penile penetration. The woman’s sexual performance is being judged and her own pleasure and feelings are ultimately ignored. “These women, and often their practitioners, attribute “success” to the ability to allow penetration, even when this occurs in a disconnected or painful manner” (Rosenbaum, 2013 p.22). Sexual pleasure may be a more appropriate goal than penetration (Heiman, 2007, p.131).

Current Approaches: Dilator- Therapy

Another physical treatment similar to pelvic floor therapy is goal orientated dilator therapy. Either working with a sex therapist or a medical professional, the client uses vaginal inserts to monitor her level of pain upon insertion. It has, however, been reported that this form of therapy is found to be too “technical, embarrassing, invasive and aversive” by the clients taking part. (Rosenbaum, 2013, p.24). Alternatively, medical methods such as lidocaine, estrogen, anti-depressants and surgery are often used alongside physical therapy and dilator-therapy (Rosenbaum, 2013, p.24).

Current Approaches: Cognitive Behavioural Therapy

Another approach used for managing female sexual pain disorders is Cognitive Behavioural Therapy. Due to the psychosomatic factors in sexual dysfunction, CBT has been viewed as an optimal treatment for many sexual disorders. It is seen as a workable alternative option for the once widely used physical and medical interventions. CBT has proved to be a successful approach at times. However, there have also been many questionable elements in this approach. Despite the problem areas of this intervention, it has been a good basis for initiating more talking therapies into the treatment of sexual pain disorders (LoFrisco, 2011, p.573). In the treatment of other pain disorders e.g. chronic pain, CBT has shown success, especially when used together with physical interventions. Therefore, it would make sense that the same approach would be useful when treating sexual pain disorders (LoFrisco, 2011, p.574). As previously discussed, sexual pain can be caused by anxiety. CBT has frequently been perceived as an effective therapeutic approach when dealing with anxiety (Corey, 2013, p.283). Therefore, considering the links between sexual anxiety and sexual pain, it becomes evident that CBT would also be useful in reducing sexual anxiety and thus alleviating or minimizing the symptoms of sexual pain. “Cognitive strategies to reduce anxiety are an important ingredient for this treatment” (LoFrisco, 2011, p.574). Heiman suggests various techniques of working cognitively in this area, such as creating alternative ways of thinking about pain during sex at different times throughout sexual encounters. For example, managing thoughts during sexual play e.g. when one might start to anticipate pain, alter the thoughts to anticipate pleasure (Heiman, 2007, p.145). CBT combines both cognitive and behavioural strategies to combat the issue. While working on their thought disorders or negative thinking patterns, the person can also take part in behavioural experiments to explore what is helpful or unhelpful. “Cognitive strategies aimed at increasing self-efficacy

as well as controlling catastrophization and hyper vigilance will contribute to the reduction of pain and improvement of sexual functioning” (Heiman, 2007, p. 145). These approaches could include the tracking of pain in a diary or practicing breathing techniques (Heiman, 2007, p. 145). LoFrisco explores multiple studies in which CBT is used to treat female sexual pain disorders. She recognises the potential CBT has to manage these disorders, yet she also identifies some problem areas. She challenges the sustainability of CBT and questions the lack of consideration towards the components of the relationship between the sexual partners. She is of the opinion that the cause of the sexual dysfunction would need attention in order for the overall sexual experience to see positive results. She suggests the therapy should include different ways of exploring intimacy for struggling couples (LoFrisco, 2011, pp. 578-579).

In 2007 Heiman used CBT to treat sexual pain and involved both parties in the relationship. She found it crucial to involve the partner at some stage in the therapy in order for it to be in any way effective. She recommended placing some responsibility on the partner of the sufferer to increase their sense of control in facilitating the situation, rather than remaining helpless and discouraged. Together they “can be educated concerning their mutual responsibility in re-establishing a satisfying sex life, independent of the changes in pain” (Heiman, 2007, p.146). Although CBT has shown good results for certain aspects of sexual anxiety, it has not been extremely effective in battling the negative self-talk that occurs during a sexual experience and it is these self-critical cognitions that are believed to be the most prominent component of sexual anxiety. However, mindfulness, which is considered to be part of the third wave expansion of traditional CBT methods, is thought to show a much greater response when minimizing the power of negative critical thoughts against oneself

within a sexual setting (Brotto, 2013, p.64). Where CBT is change oriented, mindfulness focuses on acceptance as a means of reducing stress and anxiety (Brotto, Basson, Smith, Driscoll, Sadownik, 2015, p.418).

Chapter 2

What is Mindfulness & Why would it be an Effective Therapeutic Approach for Women Suffering from Anxiety-Related Sexual Pain?

“For Mindfulness is none other than the capacity we already have to know what is actually happening as it is happening” - Jon Kabat- Zinn, Coming to Our Senses: Healing Ourselves and the World through Mindfulness

This chapter will explore the characteristics of mindfulness and the positive effects the practice has on one’s attitudes and responses to anxiety, pain and sex. In addition, the benefits of mindfulness will be applied to anxiety-related sexual pain and reviewed.

What is Mindfulness?

Buddhist philosophies and traditions have been inspiring professionals in psychological fields since the 1960s. In recent years the various third wave cognitive behavioural therapies have been drawing from these Buddhist meditative rituals. Jon Kabat-Zinn created the first course centered on mindfulness with the aim to reduce stress and depression: Mindfulness Based Stress Reduction (Zoysa, 2016, p.362). Kabat Zinn’s mindfulness based stress reduction program focuses on experiential education. The aim of this therapy is to allow the clients to apply what they learn in therapy to their experiences in day-to-day living. The program focuses on breathing techniques and meditative exercises that help the client learn how to live fully in the present moment without worrying about the outcome of that moment. Participants develop the ability to acknowledge their accompanying thoughts as simply thoughts and not something that can control them (Corey, 2013, p.212). Mindfulness can be practiced formally

through mediation or informally by increasing our awareness around the present moment in our day-to-day activities. The formal practice is used to encourage the informal practice when re-engaging with our day-to-day life (Hassed & McKenzie, 2012, p.29). “Group members learn informal practices that encourage close attention to the ordinary rote experiences of daily life as a hedge against depression - eating a meal mindfully, monitoring the physical sensations while brushing teeth...” (Sagel, 2008, p.3).

Acceptance, self-compassion and a nonjudgmental attitude towards oneself and the present moment are characteristics of mindfulness. These outlooks have proven to be useful in treating many pain-related disorders triggered by stress and anxiety (Brotto, 2015, p.418). Mindfulness “is the practice of paying attention: knowing where our attention is and being able to choose where to direct it. A slightly more technical definition would be ‘attention training’ or ‘attention regulation’”(Hassed & McKenzie, 2012, p.5). Mindfulness takes us away from living inside our heads and focusing on our anxieties and worries. Instead, we train ourselves to live in the reality of the present moment (Hassed & McKenzie, 2012, p.18). Mindfulness teaches people how to accept their present situation instead of obsessing over the past or future. Mindfulness is about embracing the here and now and not wishing things were different from how they are (Corey, 2013, p.252). It can be a useful tool for altering the perceptions of one’s own experiences by weakening the tie between the person’s present moment and their destructive thoughts (Kimmes, et al., 2015, p.289). “We teach participants to look at their negative thoughts as creations of their minds and not facts – not real reflections of themselves” (Sagel, 2008, p.3). Mindfulness has become increasingly popular over the last few decades and has contributed to the management of various psychological disorders (Kimmes, Mallory, Cameron, Kose, 2015, p.288).

Benefits of Mindfulness

Mindfulness teaches people to live in the moment without judgment of oneself or one's thoughts or even the moment itself. It is this practice that has proven to reduce negative automatic thoughts and self-judging behaviours. "Mindfulness has been linked to a reduction in distress caused by negative, dysfunctional, and ruminative thoughts, as well as decreased stress reactivity, anxiety and worries" (Dunkley et al., 2015, p.92). It has also been shown to promote self-compassion and, as a result, improve a person's state of mind (Fjorback, Arendt, Ornbol, Fink, Walach, 2001, pp.102-118). In recent years, there has been a lot of research to prove the success of using mindfulness when coping with both physiological and psychological problems. This evidence has prompted many academics to research mindfulness as a valuable way of approaching sexual complications (Kimmes, et al., 2015, p.289). In recent years, mindfulness has been proven to actually change the composition of the brain. Findings suggest that certain areas of the brain of those who practice mindfulness daily for a minimum of eight weeks are likely to change. These areas of the brain are those that contribute to our awareness, "learning and the regulation of emotion" (Baime, 2011, p.46). Similar to the positive effect physical exercise has on our bodies, training our brain also shows encouraging results (Baime, 2011, p.46).

Mindfulness & Pain

Mindfulness looks at how we respond and connect with pain rather than the existence of the pain itself. The best way to react to pain is to recognise its presence in the first place rather than try to ignore it or distract ourselves from it, like many people tend to do (Hassed & McKenzie, 2012, p.183). Pain can be looked at in two ways; primary and secondary. Primary pain is seen as a direct symptom of a physical ailment, for instance arthritis or nerve damage.

Secondary pain, however, “comes from a tensing of our body in response to a primary pain and also an associated anxiety or anger or other negative mental state of non-acceptance” (Hassed & McKenzie, 2012, p.185). Hassed and McKenzie compare this to a trip to the dentist. explaining how we may be experiencing distress and anguish long before we are sitting in the dentist chair. So essentially the expectation of discomfort beforehand can greatly influence the level of suffering in the actual moment (Hassed & McKenzie, 2012, p.186). So if we were to look at this in relation to sexual pain, it would imply that the anticipation of the pain of penetration might impact the physical sensation itself; that it may be the perception or prediction of pain that causes suffering. The practice of mindfulness “addresses perceptions, feelings, attitudes and thoughts and allows clients to recognize how cognitive judgment of their feelings and their symptoms actually negatively affects their symptoms” (Rosenbaum, 2013, p.23). This is not to say the pain is imagined, but it highlights how our unconscious thoughts can affect the response to the pain and therefore the intensity with which we feel it. Mindfulness has the ability to moderate sexual pain as it has been shown to reduce muscle spasm, pacify pain pathways in the brain and it has also shown the ability to improve “mood and coping and reduces emotional reactivity” (Hassed & McKenzie, 2012, p.188).

Mindfulness & Anxiety

There is also plenty of evidence to suggest that mindfulness can be a useful intervention for anxiety. Anxiety is one of the first conditions in which mindfulness has been scientifically proven to reduce symptoms (Hassed & McKenzie, 2012, p.115). Jon Kabat Zinn’s study in 1992 showed vast improvements in 90 percent of the people who took part in an 8-week mindfulness programme aimed at treating anxiety and panic disorders. In more recent times, studies have also found that “mindfulness not only helps people’s mood to improve but it also

quiets the stress/anxiety center of the brain, called the amygdala” (Hassed & McKenzie, 2012, p.116). Mindfulness has been used to help women suffering with sexual pain by providing them with the ability to acknowledge and accept their anxiety, rather than struggle to fight it (Rosenbaum, 2013, p.23).

As previously discussed, there is often a link between anxiety and sexual dysfunction. It is usually not the anxiety itself but the way in which one relates to their anxiety that causes the sexual dysfunction. When confronted with anxiety, many people tend to suppress or avoid the uncomfortable thoughts and feelings rather than acknowledge them. Unfortunately, this avoidance only makes things worse and leaves the person in much greater distress over time (Kimmes et al., 2015, p.286). By using mindfulness in therapy, the client will hopefully learn to accept their thoughts and feelings and adopt a non-judgmental approach towards their sexual experiences. However, it is crucial to consider the level of difficulty for some clients in achieving this mindful state, as they are likely experiencing embarrassment or shame surrounding their sexual desires. Nonetheless, the aim of this practice would be to allow them to let go of the anxiety and negative thoughts surrounding these desires and embrace the present moment, freeing themselves from the shackles of self-doubt and criticism (Kimmes et al., 2015, p.287).

“By cultivating a mindful state, a quality of consciousness characterized non-judgmental awareness of one’s experiences in the present moment (Brown & Ryan, 2003), individuals learn to loosen the grip of anxiety by allowing oneself to “be with” the thoughts, emotions and physiological symptoms with which anxiety associated” (Kimmes et al., 2015, p.287).

Mindfulness & Self- Esteem

Many women suffering from anxiety-related sexual pain disorder experience low self-esteem and frequently “report that the symptoms significantly diminish their feelings of femininity” (American Psychiatric Association, 2013, p.438). Therefore, it is not surprising that negative reasoning and sexual dysfunctions are often connected (Kocis & Newbury-Helps, 2016, p.690). Mindfulness is known to help people develop more self-compassion and, as a result, increase self-esteem. People struggling with low self-esteem are known to feel lesser than others and they tend to condemn themselves as a result of these feelings. Mindfulness teaches one self-acceptance and kindness. It encourages the individual to let go of the criticism they inflict upon themselves (Neff, 2011, p.10). Higher self-esteem has been reported in those who practice mindfulness techniques. “Treatment methods aimed at fostering greater levels of mindfulness may help subdue tendencies to evaluate the self in negative terms, promote greater self-acceptance and encourage behaviours that are not driven by anxieties to protect self-esteem, but are congruent with one’s true self and values” (Rasmussen, Pidgeon, 2010, p.228). Mindfulness has also been linked to promoting a more positive body image amongst women through reducing negative self-talk (Dunkley et al., 2015, p.94).

As discussed, mindfulness encourages self-acceptance and an increased awareness of each present moment. Therefore, mindfulness would be a useful intervention for women experiencing anxiety-related sexual pain. Women can learn to put all insecurities aside and safely connect to the sexual experience, enhancing pleasure and connection to their sexual partner (Rosenbaum, 2013, p.20). A woman struggling with sexual pain can learn to recognize her negative and obstructive thoughts and, as a result, she can identify the upsetting

feelings that accompany these thoughts. Through the recognition of these feelings she can allow herself to fully feel them, rather than try to ignore them. This mindfulness process restores control to the woman over her body as she can “focus on and accept feelings and perceptions, whether they refer to physical perception of pain, the physical manifestations of anxiety or emotional feelings such as of shame, exposure, sadness and frustration, and to recognize thoughts as mental sensations that may be simply observed rather than followed” (Rosenbaum, 2013, p.23).

Mindful Sex

In recent years, various forms of therapy which focus on the body, such as massage and reflexology, have grown in popularity. It is possible that these practices may be a favorable way of educating people on how to give, accept and respond to touch i.e. “to learn forms of physical expression that have to do with the whole body, play and trust rather than the genitals, orgasm and danger” (Peterson, 1994, p.63). In a world saturated by the media and pornographic images and videos, have we forgotten how to explore our sensuality alongside our sexual aspirations? Long before we became influenced by these modern day distractions, the early sexual skill of tantra was practiced by Chinese, Tibetans and Indians. Not unlike mindfulness, tantric (translates as “expansion” or “weaving”) focused on “conscious touch” and energy and could be practiced both sexually and non-sexually (Peterson, 1994, p.63). “Our hands can learn to listen to another’s body as if hearing the most astonishing music” (Peterson, 1994, p.63).

William Masters and Virginia Johnson in 1970 created a form of therapy referred to as ‘Sensate Focus’. “Sensate Focus involves structured and progressive touching between two

partners, advancing from initially non-genital touch to more pleasure orientated touch in subsequent stages” (Brotto, 2013, p.63) Although not directly connected, sensate focus therapy draws from many of the attributes of both tantra and mindfulness meditation. It pays direct attention to the present moment and focuses on the sensation of a partner’s touch. However, although the two forms of therapy are comparable and can be intertwined when dealing with sexual anxiety, mindfulness allows one to work on their sexual dysfunction outside of a partnership. Sensate focus requires one to pay attention solely to the touch of their partner, while mindfulness pays attention to various different aspects of the present moment (breath, sounds, taste etc.). Therefore women suffering from anxiety related sexual pain have the opportunity to overcome their struggle without having to rely on a partner (Brotto, 2013, pp.63-64).

“When applied to sexual concerns, where distressing sexual interactions may produce an endless stream of negative thoughts and judgments, mindfulness may be an effective way of re-routing one’s negative memories or anticipated sexual disasters onto the sensations that are unfolding in the moment” (Brotto, 2013, p.65). Behaving mindfully before, during and after sex increases a person’s ability to stay connected to their partner and set aside any intruding judgmental cognitions. Therefore, practicing mindfulness weakens the negative thought processes that inhibit one’s ability to open up sexually (Kimmes et al., 2015, p.289). Hence, the practice opens up an opportunity for a more meaningful experience (Rosenbaum, 2013, p.22). By remaining attentive to the feeling of each moment of being touched, it is thought that mindfulness can be effective in building sexual pleasure in women who suffer with sexual pain (Kocis & Newbury-Helps, 2016, p.691).

Mindfulness allows a person to focus on the present moment and the surrounding sensations

within that moment. Usually, used as a solitary practice, if one is to integrate mindfulness techniques into their sexual experiences, they can focus on the present moment with their partner and the feeling of their partner's touch. Someone suffering with sexual anxiety can practice mindfulness techniques themselves in order to then apply these to their sex life. Then, when in a sexual relationship, they can involve their partner in the practice (Brotto, 2013, p.63). They can learn to accept any anxious thoughts creeping into the moment and let them go with ease. So instead of focusing on self-judgments and past experiences, and predicting an embarrassing or painful moment ahead, they can instead focus on the feelings and sensations of their partner's embrace (Brotto, 2013, p.65). Through remaining engaged in the experience with their partner, they learn to not get wrapped up in anxiety. By involving their partner in the process, they can better communicate the experience and reactions to each other's touches (Brotto, 2013, p.63). Aspects of mindfulness that one may consider beneficial in a sexual relationship could be "(1) regulation of attention to keep it focused on the immediate experience, and (2) approaching one's experience with curiosity, openness and acceptance" (Brotto, 2013, p. 64). Many women who experience anxiety-related sexual pain describe it as their minds and bodies being detached from one another. In other words, their sense of desire and arousal does not match their body's physical response. Considering this, it may be a fundamental aspect of their healing to re-connect their body and mind through the acceptance and kindness that mindfulness encompasses (Brotto, 2013, p.64). When used to combat anxiety-related sexual pain, studies have shown that mindfulness "may increase attention regulation, body awareness, emotion regulation and changes in perspectives of the self" (Brotto, 2013, p.65). This increase of focusing on the present moment can not only reduce anxiety but also change one's relationship with the sexual pain they experience. Similar to letting go of the negative thoughts, one comes to accept the pain as something that

will pass, rather than attaching to it and becoming overwhelmed, thus decreasing the amount of distress the pain causes (Brotto, 2013, p.66).

“The link between mindfulness and numerous aspects of psychological and sexual well-being speaks to the potential for mindfulness techniques to serve as a psychological buffer against the damaging effects of sexual insecurities” (Dunkley et al., 2015, p.94).

Chapter 3

Further Exploring the Benefits of Using Mindfulness as an Approach for Female Sexual Anxiety & Pain.

“In a rush to reach the genitals and intercourse, we take the straight and narrow freeway and miss the astonishing, lavish countryside of the body itself” - Peterson, Sacred Sex

This chapter further explores the benefits of mindfulness as a valuable therapeutic practice for women struggling with anxiety-related sexual pain complications. The advantages of the therapeutic space will be studied. The significant factors and qualities the therapist should aim to achieve in this process will be examined also.

A dissatisfaction with one’s sex life or sexual difficulties often lead women to therapy because of the stress and conflict this can create in their relationships, both with their partner and within themselves (Brotto & Luria, 2014, p.18). Psychotherapy can be valuable to someone struggling with sexual problems as the therapist can provide understanding and empathy, alongside a space where the client can freely explore the emotional and sociological factors affecting her sexual functioning e.g. cultural background, sexual myths and stereotypes, and past and present relationships. Within therapy, the client can discuss her sexual desires without judgment or dispute. The non-judgmental space provided by a psychotherapist liberates the client in a way so they can develop the confidence to make their own sexual choices (Southern & Cade, 2011, pp.247-251).

In recent years, the range of approaches within sex therapy has grown (Binik, Hall, 2014,

p.1). As discussed in the previous chapter, mindfulness has flourished as an intervention for various psychological problems and more recently has proven to be effective in the treatment of certain sexual dysfunctions (Brotto & Luria, 2014, p.32). The therapy room provides a space where the client can learn mindful skills, which can then be utilized within their sexual experiences.

Precautions

If a therapist is considering using a mindfulness-based intervention to facilitate the client's difficulty, then it is imperative that the therapist herself/himself is fully experienced and trained in the practice of mindfulness. The therapist's own personal experience of mindfulness ensures the delivery of the technique is more likely to be successfully understood by the client. Without this element, the therapist and client relationship may be strained as the client may experience greater distress in trying to undertake this new way of being (Zoysa, 2016, p.367).

In order for the client to fully engage in the process, it is important that they are educated on the basics of mindfulness. It would be helpful for the therapist to briefly introduce the client to the practice and its beneficial outcomes (Kimmes et al., 2015, p.290).

It is also important to note that mindfulness may not always be the best approach for each particular client. The practice itself takes a lot of hard work and commitment and, in order to see results, one must show a willingness to participate. This could prove difficult for someone in a deep depression or suffering psychosis, as they may not have the motivation or ability to commit. Nevertheless, mindfulness has been proven to prevent a relapse in depression in

those who choose to commit to the program (Fjorback et al., 2001, pp.102-118).

The Role of the Therapist

“Mindfulness practices hinge on cultivating a form of awareness that is non-judgmental in nature, so firm appraisals regarding what is acceptable sexually are antithetical to such practices” (Kimmes et al., 2015, p.294). Researchers have recommended that therapists attempt to create a safe and comfortable environment, free from judgment, in order for the client to be comfortable discussing this sensitive information. They suggest the therapist should only use language the client would be familiar with. Sex talk should be relaxed and natural in the initial session and throughout in order to reassure the client and prevent reinforcing any feelings of shame (Kimmes et al., 2015, p.289). As discussed in Chapter two, mindfulness aims to put aside any negative self-talk. Hence, it is important the therapist highlight the client’s negative self-talk and encourage them to learn self-acceptance. It is the critical inner voice that ties sexual insecurities together with the present moment. In this case, when it occurs during sex, it spoils the possibility of pleasure. Sex can become an event that creates dread and panic. No longer focused on affection or sensations, we can become distracted by off-putting thoughts. “The voice influences people to deny themselves pleasure and causes them to give up their natural desires and wants and to conform to prohibitions” (Laing, 2002, p.102).

The therapist should aim to depict mindfulness as a gradual process of self-discovery, rather than a treatment program for a dysfunction (Rosenbaum, 2013, p.26). It is also beneficial for the therapist to promote and acknowledge the client’s efforts where possible.

Although mindfulness deals only with the present moment and does not delve into the past, in

the initial session it may be beneficial to discuss the client's sexual background and develop a context for their sexual pain. It may be helpful to identify the past issues that have caused the person to build a barrier against emotional or physical intimacy. A person's sexual history and outcome predictions could be an important part of the resolution (Ziegler, 1990, pp.15-16). Psychotherapists can aim to provide a safe space in which the client can explore these issues without feeling any judgement or pressure. If they can practice advanced empathy and offer emotional support, it is possible that they can provide hope for the client in distress. What is most important is that the client feels accepted and in turn can accept herself. (Ziegler, 1990, pp.16-18).

In a mindfulness based client counsellor relationship, it can be valuable to avoid creating a goal-orientated therapeutic space. This helps dissuade the client from placing unrealistic expectations on herself and also depresses the anticipation of pain based on her previous memories. Instead, it is important that the client is encouraged to begin each sexual experience as a new individual happening (Rosenbaum, 2013, p.23). Looking at each experience as a fresh beginning can also prevent the body's physical reaction to the expectation of pain i.e. the contraction of the muscles in the pelvic floor (Rosenbaum, 2013, p.24). The counsellor can remind the client that although these negative thoughts may arise, they do not need to hold on to them. These thoughts can be looked at as "mental sensations that may simply be observed rather than followed" (Rosenbaum, 2013, p.23).

The Body Scan

Fostering a mindful “awareness of one’s body without being touched may lead to greater awareness of one’s bodily sensations” when engaging in sexual activity (Kimmes et al., 2015, p.290). The body scan is a mindfulness meditation technique that can be practiced within therapy alongside the practitioner and also alone outside of therapy between sessions. The body scan asks the person to take time to pay attention to each part of their body, giving each part equal attention and consideration. The awareness placed on each body part should be non-judgmental. The person is simply expected to be conscious of any physical or emotional feelings connected to the body part without criticism. Throughout the scan the client will also be encouraged to pay attention to their breathing. If the client loses focus or becomes distracted by their thoughts, they are reminded to bring their attention back to the present moment. Again, this should be handled without self-criticism. “By practicing the body scan meditation, the client develops a newfound intimacy with his or her own body” (Kimmes et al., 2015, p.290). The body scan can help women recognise the slight, less obvious changes in their physical responses inside and outside their sexual experiences (Brotto, 2013, p.66). The therapist and client can then openly discuss the body scan and the thoughts and feelings that cropped up for the client throughout the experience. In this way, the client can learn to be more accepting of themselves when engaging in the present moment. Over time this non-judgmental approach towards their physical sensations and emotional reactions can be applied to their sex lives (and other areas of life also e.g. eating, exercising) (Kimmes et al., 2015, pp.290-291). By engaging with these physical sensations, people suffering with discomfort and pain during sex can learn to change their perception around their bodily sensations and accept their thoughts and feelings as “temporary events that rise and pass with time” (Brotto, 2013, p.66).

Couples Counselling

Sexual difficulty is a common reason that couples seek therapy (Brassard et al., 2015, p.110). Often women who are suffering with genito-pelvic pain/penetration struggle with relationship problems as a result (American Psychiatric Association, 2013, p.438). Therefore, it is important to explore the reaction of the partner and their role in the sexual relationship. Research has shown that the more facilitative the partner is in dealing with the female's pain, the more likely that improvements will take place. Similarly, the more negative the partner's response, the more likely the female will continue to experience pain. In other words, the way the partner understands the pain has a further impact on the woman's pain. Sexual pain can also be extremely emotionally upsetting for the partner. "These common gynecological pain conditions all result in significant sexual, psychological and relationship impairments, which are as much a source of distress for the patient and her partner as the pain itself" (Bergeron et al., 2015).

Approaching sex mindfully fosters acceptance and trust between the partners. It is important that couples recognize they are working together, rather than all the focus being on the symptomatic woman. Therefore, it is important that the therapist mirrors this sense of collaboration and avoids victimizing the client experiencing this dysfunction. Similar to one to one counselling, the therapist should steer clear of using or supporting any goal-orientated language (Rosenbaum, 2013, p.25). Instead "the couple is instructed to focus on the sensations of breathing together, touching each other and ascribing new meanings to their sexual connection" (Rosenbaum, 2013, p.26). Any physically intimate activity should be enjoyed in itself and not be looked at as a gateway to intercourse. This removes pressure and allows the couple to develop an appreciation for the moment-to-moment present experience

(Rosenbaum, 2013, p.26). Where penetration is painful, the client can be encouraged to progress step by step with her sexual partner. She should remain in control and consciously aware of each moment as opposed to being submissive throughout the experience. By taking control she can build trust with her partner (Rosenbaum, 2013, p.25).

Case studies

Lori A. Brotto & Julia Heiman formed the first mindfulness-based therapy that dealt specifically with sexual dysfunction in 2003. They first applied this to female sexual arousal disorder. Their subjects were 22 women who had survived gynaecologic cancer (Brotto, 2013, p.64). After educating the women with basic mindfulness skills, they advanced to practicing more sensual mindful activities and incorporated sensate focus therapy into the mix. The results were positive as most areas of sexual functioning were enhanced and, as a result, the overall mood of the women improved. Most importantly, the women found the mindfulness techniques specifically to be the most useful in their sexual recovery (Brotto, 2013, p.65).

In a study published in 2015, Dunkley, Goldsmith and Gorzalka identified higher levels of sexual fulfillment and lower levels of sexual insecurities in those who practiced mindfulness as opposed to those who did not. This study also found that it was the mindfulness practice that facilitated the higher sexual self-esteem and satisfaction. Through using mindfulness, criticisms of body image and performance were significantly less. A non-judgmental attitude and heightened awareness of the present moment were linked to the elevated levels in gratification. This study was carried out on both male and female participants through the use of an online survey (Dunkley et al., 2015, pp. 92-102).

Mc Creary and Alderson have discussed the usefulness of mindfulness meditation in relation to sexual intimacy. They have focused primarily on women. Interviews were carried out among a small number of women (10) who agreed to practice this form of meditation over the course of six months. Through performing this meditation, the participants were able to observe their own negative thought processes, “accepting whatever arises as it is, without effort or desire to change it” (Mc Creary, Alderson, 2013, p.105). The result of this allowed the women to emotionally disengage from the negative thoughts (while still being aware of their passing presence) and remain present with their sexual partner. The women responded positively to the intervention and found it more helpful than previous therapies they had tried. “It helped to (1) increase sexual desire, (2) improve their awareness of arousal responses that were still occurring...(3) improve perception of their bodies and (4) decrease sexual distress (Mc Creary, Alderson, 2013 p.106).

Kocis and Newman-Helps conducted a study to explore the value of mindfulness using interviews of both male and female participants suffering with various sexual dysfunctions. What they found was that unlike the traditional therapies used, mindfulness actually cultivated consideration and empathy between sexual partners. They found their participants developed a new outlook on sex; having previously avoided sex due to their dysfunction, they were now more willing to let go of their obsession over the potential consequences (Kocis & Newman-Helps, 2016, pp.690-699).

Conclusion

With an understanding that sexual anxiety and sexual pain are connected, the American Psychiatric Association have coined these dysfunctions under the umbrella of “Genito-pelvic pain/penetration disorder” (American Psychiatric Association, 2013, p.437). In our modern day society, the subject of sex and sexuality is no longer off limits and is now becoming a more widely accepted and standard topic of conversation. Despite this progress, sexual anxiety remains present and disruptive in the lives of many today (Williams & Jovanovic, 2014, p.158).

Mindfulness is both a mode of meditation and a way of being that has been practiced for an age and in recent years has seen a rise in recognition. Through practicing mindfulness, one can learn to center their attention on the present moment and, as a result, separate themselves from the distractions and worries that may be disrupting their mental and physical health (Hassed & Mc Kenzie, 2012, p.6). In the past many characteristics attached to mindfulness were employed to enhance sexual well-being from the ancient art of tantra to sensate focus therapy. More recently, mindfulness itself has seen success in ameliorating sexual dis-satisfaction.

Thus, through the examination of the wide-ranging literature and experimental studies, the aim of this thesis was to build knowledge surrounding anxiety-related sexual pain and demonstrate mindfulness as a beneficial therapeutic approach. The intention for this study was to increase the awareness of anxiety-related sexual pain and to examine the various ways in which mindfulness has the ability to settle the psychological elements that are thought to

contribute to this pain. Furthermore, it was thought that the consideration of this information would encourage an empathetic approach to its treatment in regards to both the therapist and the sufferer themselves.

This thesis examined the traditional ways in which women suffering with genito-pelvic pain/penetration disorder were cared for and the limitations of said remedies. Traditionally women experiencing sexual pain were treated physically and medically, quite often in intrusive ways which resulted in greater distress. With characteristics of sexual anxiety and pain involving trepidation around being touched, there is an indication that the disorder could be more successfully treated outside clinical methodologies. Consequently, the idea is that anxiety-related sexual pain (alongside various other sexual dysfunctions) might be better approached within a therapeutic setting. This concept is supported by literature that suggests an assortment of cognitive distortions as the possible underlying causes for this particular sexual difficulty (Rosenbaum, 2013, pp.20-28).

This study explored the recent rise in the popularity of mindfulness and looked at its uses in managing both mental and physical complaints, including anxiety and pain (Hassed & McKenzie, 2012, pp.89-181). The main concept of mindfulness is to focus on the present moment and this practice has proven to reduce negative thoughts and, as a result, reduce the physical and mental symptoms caused by these distracting cognitions (Dunkley et al., 2015, p.92).

Literature supporting mindfulness as an effective treatment method for sexual pain was considered and discussed in this thesis. The tools of mindfulness were shown to be capable of

inspiring self-compassion and releasing oneself from the grip of negative self-talk. The literature suggested that this ability to stay in the present moment could connect one mentally and physically to their sexual desires, uninterrupted by distorted cognitions or worries (Brotto, 2013, pp.63-65).

Various experimental case studies were looked at in order to support this thesis. These case studies showed promising results in the use of mindfulness when treating sexual dysfunctions. Within these studies, the practice of mindfulness was proven to reduce negative thoughts during sex, improve sexual arousal and self-esteem, and overall sexual functioning was enhanced.

The literature and investigations considered in this thesis authenticate mindfulness as a valuable method of therapeutic intervention in the alleviation or reduction of anxiety-related sexual pain. This physical pain is more often than not an indication of emotional suffering. Therefore, this thesis has observed the benefits of treating this disorder in a therapeutic rather than clinical setting. As discussed, the components of mindfulness have proven effective in not only relieving physical pain and emotional distresses such as anxiety, but also in enhancing sexual intimacy and satisfaction. With this in mind, mindfulness should also be considered as an effective approach for treating those with anxiety-related sexual pain i.e. genito-pelvic pain/penetration disorder.

Having consolidated and considered the various relevant literature and studies, the author has accomplished the objective of this thesis. Upon review, the author feels there is room for deeper study to be done in this area. The author suggests further experimental studies to be

carried out, examining the results of mindfulness as an effective approach for genito-pelvic penetration/pain disorder. As discussed in the final chapter, the author suggests using an integrative approach alongside mindfulness as a treatment method. Discovering the cause of the dysfunction may also be useful to the client's recovery and self-awareness. Having analysed the research findings, the author supports the idea that any therapist considering using this approach be well versed and trained in the practice of mindfulness in order to avoid risking any harm to the client.

Although this study has solely concentrated on women, sexual pain has also been reported within the male population. When it comes to sexual pain in men, the area is far less understood and treatments far more traditional i.e. medically treated. Studies have found that 5-15% of men across the global suffer from pelvic pain also known as chronic prostatitis. The exact location of the pain can fluctuate but can range from pain from legs to pelvis and testicles. Ejaculatory pain is also a known symptom (Davis, Binik, Carrier, 2009, pp.182-205). Studies have shown many men prefer to seek medical solutions rather than psychotherapy based options (Berry, 2012, p.249). However, mindfulness has been found to alleviate symptoms of some sexual dysfunction in men such as low sexual desire and erectile dysfunction (Brotto, 2013, p.66). Therefore the author feels it would be interesting to investigate mindfulness as a therapeutic approach for men presenting with sexual pain also.

The research surrounding genito-pelvic penetration/pain disorder primarily focuses on heterosexual couples. Nonetheless the author recognises the importance of acknowledging the LGBTQ (lesbian, gay, bisexual, transgender, queer) population. As mentioned above, sexual pain disorders occur most commonly in women, but studies do show a small number

of the male population reporting symptoms of this sexual dysfunction. Mindfulness techniques are not gender specific and therefore can be applied to both women and men in heterosexual, bisexual and same sex couples inclusively (Binik, Hall, 2014, p.7).

“Be small. Be nothing. Stop Stirring. Be as small as a petal on a daisy, humming bird tiny. Be nothing as space is nothing, as air is nothing. Stop striving and fall back into the arms of the universe. This is how I have learned to rest. My head is the lap of infinity” - Mary McEvoy, Ordinary Beauty

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