

Sexocorporel in the promotion of sexual pleasure

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Sexocorporel is an encompassing view of human sexuality that considers all of the physiological, emotional, cognitive and relational components involved in a sexual experience. Developed by Prof. Jean-Yves Desjardins at the Sexological Department of the University of Montreal, Quebec, in the 80s, it has since been applied, taught and refined by sexologists in Canada and various European countries. The promotion of sexual pleasure is a central goal in Sexocorporel sexual therapy. To understand how this is achieved, we will take a closer look at its concept of sexual health. Sexocorporel proposes a definition of sexual health based on the ability to experience sexual pleasure (Desjardins 1996). In sexology in general, the role of sexual pleasure is often astonishingly neglected. Research on sexual pleasure is barely beginning (Komisaruk 2010). Non-sexual pleasures consist of sensorial, affective and cognitive components (Kringelbach 2009). In Sexocorporel, the same components are ascribed to sexual pleasure, and conditions are defined for their optimal functionality in order to allow for maximum pleasure: (1) *physiological component*: the ability to raise one's genital sexual arousal to orgasmic discharge using the body in an optimal way to permit hedonic (pleasurable) physical sensations; (2) *affective component*: the ability to perceive one's physical sensations during arousal and orgasm combined with intense hedonic emotions and emotional release; and (3) *cognitive component*: the ability to give positive meaning to the experience. In reality, these components closely interact, for didactic purpose, we regard them separately.

1. *The physiological components of sexual pleasure*

Genital sexual arousal feels good. This observation seems common sense, and yet it is not a given. Many of our clients seek us precisely because they don't experience it that way. Strangely enough, many sex therapy schools don't particularly take into account the actual genital reality of a person's sexual experience. In Sexocorporel, this is a core issue. Genital sexual arousal is based on an innate reflex. This reflex can be triggered by a great number of sources and stimuli. In male fetuses, it can already be observed intrauterinely. It causes genital vasocongestion, an acceleration of breathing, a heightening of muscle tone, as well as a number of concomitant changes of the autonomic nervous system. Once genital vasocongestion reaches a threshold, and through the influence of a number of factors not altogether understood, a second reflex-like reaction is triggered – the orgasmic discharge, accompanied by spasmodic muscle contractions and followed by resolution.

Since Masters and Johnson, this sexual response cycle has been described and researched in physiological detail. The mere process of the cycle in and of itself, however, does not give us any indication of the quality of the experience, nor, in fact, whether it is perceived at all. Particularly in women, genital sexual arousal according to

laboratory measurements may not necessarily be felt or perceived as pleasant (Meston 1995). Genital vasocongestion causes sensations of warmth, tingling, tension, pressure, moisture etc. Unlike vasocongestion in other parts of the body, these sensations can be perceived in a pleasurable way unique to genital sexual arousal. They are not, however, automatically perceived that way. Clinical experience, as in the case of anorgastic women, shows that the ability to perceive them is acquired through practice. These women often start out with very little pleasurable perception of their genitals. They may consult with the very question: "Do I have a clitoris at all? I feel nothing there." The suggestion to practice repetitive stimulation of the vulva and vagina is a successful intervention. Neurologically, this repetitive stimulation of peripheral sensory nerve receptors leads to a development of corresponding synapses in the somatosensory cortex and in the brain's pleasure centers. Many women reach adulthood without having had much occasion, permission or even encouragement to play with their own genitals and develop such synapses. This is one of the reasons why difficulties with orgasm, particularly in partner sex or during intercourse, are among the most common complaints in women, much more so than in men, who from early age on usually have tactile and visual contact with their genitals and hence a better chance of developing certain synapses. But even men in their habits of self-stimulation often don't make use of the full neurological potential of their genitals and may find their arousal compromised in partner sex.

This leads us to a second important physiological reason for difficulties getting aroused with a partner or deriving pleasure from this arousal. Desjardins observed that humans tend to employ their bodies in preferred and repetitive patterns during sexual arousal that are likely to have an influence on the perception and the emotional experience of this arousal (Chatton 2005). He called these patterns the *sexual arousal modes*. Empirical data show that there are essentially 4 different types of arousal modes, with very different consequences for the experience of sexual pleasure. Desjardins noted that the acquisition of a particular arousal mode was the result of a learning process. Parental and pediatric observations and video materials demonstrate that infants at the very young age of 3-6 months are first able to elicit sexual arousal by applying rhythmic pressure to their genital and pelvic region. Yang (2005), Hansen (2008) and others described self stimulation in children as applying pressure to their genital region through muscle tension while performing stereotypical, "dystonia-like" movements of the torso, pelvis and legs, a stretching and tightening of legs and arms, accompanied by neurovegetative symptoms typical for adult sexual arousal, such as irregular breathing, grunting, sweating and facial flushing. In some instances, even spasmodic discharges were observed. The children were always conscious and could be interrupted in their activity. Neurological and other disorders were excluded – the children were all healthy and developmentally adequate. Authors and pediatricians concluded that this was non-pathological, normal infantile behavior.

Desjardins called this arousal pattern the *archaic arousal mode* – as it is the first one accessible to the human, even before the ability to perform targeted movements with the hand. A number of persons, women more often than men, maintain this arousal mode lifelong, at least during self-stimulation. Women apply pressure to their genitals or mons pubis or lower abdomen with a fist, fingers, objects such as pillows, lying on their belly or pressing against furniture, through crossing their legs and rhythmically or continually squeezing them together, and a number of other techniques that exert pressure on the pelvic region. Hands may or may not be used, however, muscle tension

is always involved. Tension can be so important that muscles are sore the next day. Breathing is shallow or may be arrested. Likely, most women who believe they reach orgasmic discharge through fantasies alone are unaware they actually exert an important degree of pelvic muscle tension. This type of stimulation always solicits deep nerve receptors as well as proprioceptors. A number of women combine it with friction of the vulva, soliciting superficial nerve endings (*archaic-mechanical arousal mode*). Men exert pressure on their penis or on neighboring structures such as the perineum or groin, often by squeezing parts or all of the penis with hands or objects, lying down on it, bending it down and squeezing it between the thighs, or rubbing it using great pressure with fingers or fist. Again, stimulation is combined with important muscular tension. Typically, the archaic arousal mode is very efficient in augmenting arousal, and an orgasmic discharge can be reached within seconds or minutes. If much pressure is used, in men ejaculation may occur with a soft or partially erect penis. The orgasmic discharge is often rather brief and focused, and the ensuing release of muscle tension is perceived as relaxing and pleasurable.

It seems to be in the nature of the sexual arousal modes that people like to stick to their habits. A number of persons acquire different modes and are able to switch between them, more stay with what first worked well. In an Italian study, 30% of women and 21% of men in a non-clinical sample of 345 persons exclusively used the archaic arousal mode to reach orgasmic discharge (Santarelli 1987). In a non-clinical sample of 1417 Swiss women aged 17-65, 47% used the archaic mode in masturbation, 19% used it during partner sex (Bischof-Campbell 2012). In clinical practice, the prevalence of an exclusive archaic mode is much higher, as it is the mode most likely to cause difficulties in partner sex: it requires the same type of stimulation as during masturbation in order to increase arousal. Women require intense, forceful penetration accompanied by high muscle tension, or a certain amount of pressure on their vulva, as can be achieved by grinding the pelvis against the partner's pubic bone, or pressing a hand against it, or favoring rear-entry penetration while prone on the belly, with the possibility to squeeze the legs together and augment muscle tension. Arousal problems and coital or partner anorgasmia are frequent with these women. Men may find the pressure exerted by a vagina or mouth on the penis insufficient and prefer anal intercourse, or use a hand to press on the base of the penis. Coital erectile dysfunction is common from a young age on. Both sexes may rely heavily on stimulation through fantasies, role plays and other mental sources of arousal because the physical stimulation through the partner is not intense enough to suit their arousal pattern.

More common is what Desjardins dubbed the *mechanical arousal mode*. It can be found in more than 50% of men and about 40% of women. Its principle is stimulation of superficial nerve receptors through rapid friction of the genitals – the vulva or clitoris, the penis or parts of the penis. The stereotypical rubbing motion can be done with little conscious investment, automatically – hence “mechanical”. Stimulation may start out more slowly and varied, and increase as arousal mounts, to show its typical rapid uniform pattern during the last minutes of the arousal curve, where it may require a very precise ritual focused on precise anatomical spots, e.g. “3mm left of the clitoral hood, with just this speed and just that pressure”. Typically, muscle tension also mounts, though to a lesser degree than with the archaic arousal mode. There may be an arching of the spine and stiffening of the pelvis, legs and abdomen, with interrupted, short breathing. Typically, during masturbation the body is very immobile while the hand does all the work. Sexual arousal is felt very locally in the area stimulated. The

mechanical arousal mode is usually a very efficient method of self-stimulation that leads to orgasmic release within a few minutes.

Again, during partner sex, a person narrowly focused on the mechanical mode will require physical stimulation in a very similar way. For heterosexual men, this may be intercourse with increasingly rapid thrusting motions of the whole torso “en bloc”, possibly requiring a vagina that supplies sufficient friction, i.e. is sufficiently tight and not too moist. Some men may prefer anal intercourse for its greater friction. Some experience erectile difficulties after childbirth if the vagina has lost tightness. Heterosexual women focusing on clitoral stimulation in masturbation may find penile-vaginal intercourse not particularly arousing, unless additional clitoral stimulation is performed. With a very narrow arousal pattern, they may require stimulation of a precision their partner, for lack of biofeedback, can’t supply. Intercourse may even be perceived as disturbing to arousal. In women with a broader mechanical mode, manual and oral stimulation by the partner can be an easy way to orgasmic release. As in the archaic mode, if physical stimulation in partner sex is experienced as insufficient, persons with the mechanical mode may focus strongly on stimulation through mental input, fantasies, role plays etc. Persons with a narrow mechanical mode may find partner sex strenuous because of the mental strain or physical exertion necessary to maintain arousal.

Individuals exclusively favoring vibrator stimulation can usually be allotted to the archaic mode, as their body reactions are similar. Vibrators solicit vibration receptors. Usually, muscle tension and pressure receptors are also involved. The same is true for stimulation via water current, such as shower or pool jets.

Both archaic and mechanical modes typically employ high muscle tension in the pelvic region, and often in adjoining parts of the body. They use little body motion and have restricted breathing. We will see later how this can be a limitation to the experience of sexual pleasure. The two remaining arousal modes, the *undulating arousal mode* and the *arousal mode in waves*, have in common great mobility of the body, deep breathing, and are accompanied by much higher levels of pleasure. Women with these modes were found to enjoy arousal, sensations in their body and vagina, and orgasm, while women with archaic and mechanical modes solely enjoyed orgasm (Bischof-Campbell, 2012). In the undulating arousal mode, the whole body moves around its vertical axis in all directions, in voluptuous fluid motions of varying muscular intensity. Exteroceptive and proprioceptive nerve endings are stimulated that way in all of the body, without a particular focus on the genital region. The undulating mode comes with a high degree of pleasurable sensations. Respiration flows freely. Movements are often slow and deliberate, to obtain maximum pleasure from the motion and the contact. Correspondingly, during autoerotic activity many parts of the body are moved, touched and stimulated. Likewise, during partner sex, the whole bodies are in varying sensual contact. The undulating mode is not geared toward orgasm, as the state of arousal itself, even if not particularly high, is so pleasurable that it can be fully satisfying. Typically, as the undulating mode goes with rather lower muscle tone, we find this mode more in women than in men, whose muscle tone physiologically is higher. Some tantra schools employ comparable techniques.

The arousal mode in waves combines undulating movements *around* the vertical body axis with a coordinated movement *in* the vertical axis called the “*double swing*”: the

pelvis is tilted so the genitals move forward during expiration and backward during inspiration in a swinging motion (the “*pelvic swing*”). Simultaneously, (the “*upper swing*”), the head tilts backwards and the sternum collapses during expiration. The double swing movement thus includes the whole spine arching outward during exhaling and inward while inhaling, with the neck doing the respective opposite. The double swing is part of the inborn mounting behavior in a number of male mammals. In the human, it is obviously not genetically inscribed, but we can observe it in other reflexive actions involving abdominal muscular spasms, such as coughing, laughing, vomiting or sobbing. It is visible in all strong emotional expressions of infants, while most adults have learned to suppress it when laughing or crying. It may be experienced during the spasms of orgasm. Movements of the mode in waves are of varying intensity, amplitude and rhythm. They solicit superficial and deep sensitive nerve receptors in all of the body, with a focus on the genital and pelvic region, thus allowing one to steer the rise of sexual arousal both during self-stimulation and during partner sex to a powerful orgasm.

In summary, arousal modes influence the experience of sexual pleasure by being more or less well suited for partner sex. Our clients are counseled to practice variation in their self stimulation in order to broaden their sensual (i.e. synaptic) repertoire and more easily nourish their arousal through the physical contact with their partner. E.g. the sensitivity of the vagina can be augmented through repetitive touch, rendering penetrative sex more pleasurable for the woman, or a man can learn to stimulate his penis more slowly and gently to mimic the softness of the vagina during intercourse. Another relevant influence of arousal modes on sexual pleasure arises from their varying degree of muscular tension, breathing and movement. As this is so important but little known, we shall explore it in detail. Specifically, tonic (=continuous, as opposed to phasic) elevated muscle tension inhibits the experience of sexual pleasure in several ways: by influencing afferent sensory neurons, the blood flow and the autonomic nervous system.

1) Muscle tension and afferent neurons

Elevated muscle tension invokes a strong stimulation of proprioceptive and deep sensory nerve endings, while it inhibits the perception of superficial stimuli. This can be easily explored by caressing one’s forearm, once with the arm relaxed, and once with the fist clenched. The same type of caress will be perceived differently, particularly if it is “limbic touch”. This slow and light caressing bypasses the somatosensory cortex and directly elicits pleasurable feelings in the left anterior insular cortex. It regulates emotional and hormonal responses and is believed to directly promote bonding with the touching person. Receptors are only found in hairy skin, and afferents are unmyelinated (Löken 2009). They react only when stroked at a particular speed (ca. 2 - 8cm/sec), and only that type of caress was associated with pleasure and wellbeing by test persons. Conversely, persons with a high muscle tension arousal mode, particularly the archaic mode, associate this touch with unpleasant perceptions. Possibly, the neurological input of high muscle tension blocks that of limbic touch, perhaps similar to the ways it blocks pain. The individual finds it ticklish and generally tries to avoid it. Some persons who “can’t stand” tender caresses have been falsely psycho-pathologized with an incapability of bonding or “emotional frigidity”, when in fact their only problem is the habit of tightening their muscles once they’re aroused. This is an important example of the body-mind unity, and how what we do with our body can influence our emotions and social

interactions. The ability to enjoy limbic touch and other caresses is learnable via modification of muscle tension.

Perhaps through similar mechanisms, elevated muscle tension in the chest, diaphragm and abdomen seems to inhibit superficial sensory nervous input from more distal body regions such as the genitals. Consequently, the sum of “hedonic input” is reduced, and the pleasurable experience is reduced. In some individuals, even the ability to raise arousal to orgasm is impaired if the diaphragm is blocked.

2) Muscle tension and blood flow

The strong tonic pelvic muscle contraction in archaic and sometimes mechanical arousal modes inhibits the *diffusion* of sexual arousal. Let us keep in mind that elevated pelvic blood flow and genital engorgement are what feels warm, tingly, pleasurable sexual during arousal. Many striated muscles are stronger than systolic blood pressure and will stop the arterial blood flow within the muscle during forceful contraction. Consequences are:

- a) Instead of muscles engorging with blood and thus augmenting the pleasant feeling of sexual tension in the pelvis, muscular ischemia and concomitant biochemical reactions ensue that become unpleasant if contractions go on for too long.
- b) Tonic muscle contraction also inhibits the blood flow to neighboring organs such as the lower third of the vagina, inhibiting vaginal engorgement and lubrication. This explains why some women even at high arousal can't sufficiently lubricate. Also, lack of vaginal engorgement inhibits the vaginal tenting necessary for the perception of an inner vaginal space and the desire to be filled – a prerequisite for coital sexual desire. Instead, the vagina may be perceived as no space at all but something solid, a “clenched ball” or a “solid tube”, as some women describe it. In some older men or men with vascular problems, tonic pelvic muscle tension seems to inhibit blood flow to the penis and can cause erectile problems.
- c) If vasocongestion is confined to the outer genitals because blood flow in the inner pelvis is reduced, the area that feels pleasantly aroused stays very small and focused – just the penis, or just the clitoris. Arousal becomes a local and reduced phenomenon – as opposed to a body in fluid motion where increased blood flow is pleasantly perceived in the whole pelvis and other body regions. Likewise, an orgasmic release is experienced as comparatively “small” if it involves just a tiny area, as opposed to larger parts of the body. Persons with an archaic or mechanical arousal mode tend to describe their orgasms as “nice”, “brief”, “like a good sneeze”, and mostly enjoy the ensuing muscular relaxation.
- d) Arousal confined to a small area of engorgement is very sensitive to disturbances: if proper stimulation is interrupted just briefly, what little vasocongestion there is can quickly drain – and arousal is lost. Women who need a very precise stimulation ritual or get easily distracted can be found in this category, as can men with erectile difficulties after a certain age.

3) Muscle tension and the autonomic nervous system

Tonic muscle tension inducing ischemia seems to lead to an activation of the sympathetic nervous system going beyond the sympathetic activation necessary for sexual arousal. Too highly elevated sympathetic stress is detrimental to sexual arousal and pleasure (Ulrich-Lay 2010).

Tension of abdominal and pelvic muscles blocks the movement of the diaphragm. Breathing becomes shallow and rapid. This type of breathing activates the fight-flight-freeze branches of the autonomic nervous system, in a way that is not conducive to experiencing sexual pleasure. Once this breathing has set in during arousal, the need to reach orgasmic discharge becomes powerful. With general hypoxia setting in due to generalized muscle tension, the body is in a veritable emergency situation, and release becomes a vital urgency. Persons experiencing this during their sexual arousal tend to aim for a rapid discharge – with the archaic mode, it can be after 30 seconds, with the mechanical mode after few minutes. There is no motivation to prolong sexual arousal, no pleasure in its increasing, only the anticipated pleasure of the discharge, the ensuing relaxation and re-oxygenization that constitute the main sensual joy of the whole act. Behind many cases of rapid ejaculation lies a mechanical mode, aiming at ejaculation and with little ability to enjoy the way there. These men may want to last longer for the partner, unaware that they themselves can gain pleasure from learning to slow down.

In summary, elevated tonic muscle tension, as can be found in a considerable number of people during sexual arousal, inhibits sexual pleasure physiologically in a number of ways. It is not, however, expedient to advise general muscle relaxation. While this can help to enjoy the experience of limbic touch and other exchanges of tenderness, it is not conducive to sexual arousal. Full relaxation of pelvic muscles usually interrupts the arousal reaction and resolution ensues. We are therefore confronted with the question of how to give the body the muscle tension it demands, while avoiding negative effects of tonic tension. The answer, obviously, is phasic muscle tension. This is best obtained through movement. Movement can create important tension in certain muscles, while simultaneously relaxing the antagonists. In the undulating arousal mode, it is this principle that leads to elevated and prolonged states of pleasure. Since, in this mode, there is no particular focus of phasic muscle tension in the genital region, reaching orgasm becomes difficult or impossible. In contrast, the pelvic swing movement of the arousal mode in waves involves muscles that favor blood flow to the genital and pelvic region: the psoas muscles, lower abdominal muscles, and the pelvic floor. It serves to raise genital sexual arousal, while keeping the whole body in motion. For that reason, it is particularly well suited to physiologically provide a maximum of pleasure during sexual arousal and orgasm. Our clients are instructed to practice the movement until it becomes automatic and then use it during sexual arousal, along with deep abdominal breathing and undulating motions of the whole body – alone at first, and, once proficient, also during partner sex. It must be kept in mind that arousal modes are trained patterns that aren't easily changed. Therefore, clients must be warned that their arousal will be impaired when they first try.

2. The emotional components of sexual pleasure

A central problem in research on the emotional components of sexual pleasure is that people, when asked what they find pleasurable about sex, are likely to give hundreds of different answers, ranging from the physical, sensual joys to happiness with its bonding and love promoting properties to gratification of narcissistic needs (Meston, Buss 2007). Therefore, what one person considers sensually lousy sex may be highly gratifying to another because of its emotional implications. If we take a closer look at the emotional implications of sex, we find two major categories: 1) security, fusion and affirmation of the relational bond: Sex is pleasurable because it shows me he loves me / we can be really close / our relationship is celebrated / I am safe with her / he won't leave me, etc.; 2) narcissistic gratification: Sex is pleasurable because it shows me I am a sexy man or woman / I am desirable or lovable / I am sexually competent, etc. While these are important properties of the experience of the sexual act, they are not directly dependent on its quality. Instead, their pleasure-enhancing properties rely on a number of personal and relational influences that are prone to change, such as the current need for validation, the quality of the relationship, etc. Sex may be experienced as highly pleasurable in a new relationship precisely because it is proof of one's desirability and of the exciting new bond developing. The emotional biochemistry of new love is so powerful it can elicit sexual arousal and orgasm. After three years of marriage, however, biochemistry is back to baseline, the bond is well established, and we know beyond satiation that the other desires us. Such emotions are highly volatile and therefore unreliable in promoting sexual pleasure. Some forms of therapy aim at rendering them more reliable, others suggest role play and similar strategies to get the emotional tension back into the sex. Sexocorporel aims at enhancing the intensity of the emotional experience, be it amorous, in search of security, or self assertive, through corporal means and by enhancing the sensual hedonic quality of sex.

A core axiom of Sexocorporel is the neurophysiological unity of body and mind, and in particular, the fact that we perceive our emotions through somatic sensations; e.g. anxiety can be felt through a tightness of the chest, joy may be a "bubbly feeling in the stomach". Modifications on the level of the body can elicit or modify emotions – try deep abdominal breathing at a moment of anxiety, and through suppression of the sympathetic and stimulation of the parasympathetic nervous system, anxiety will go down just as much as you can amplify it inversely by contracting your chest and taking rapid shallow breaths, really getting yourself into fight-or-flight mode. Mobilization of chest and diaphragm play a central role in the promotion of sexual pleasure, as, through the autonomic nervous system, they help the brain move from a hyper-attentive state into a state of slightly reduced vigilance that is essential for the experience of pleasure and letting go.

Furthermore, the intensity of emotions can be amplified by greater mobility in the chest, neck, jaw and mimic muscles. As a simple experiment, try a yell of enthusiasm that you put your whole body into. Then do the same yell with a clenched jaw, freezing your chest, neck and facial expression. It will not feel the same. Persons in archaic or mechanical arousal modes show muscular rigidity in the upper part of the body at high arousal and at the point of no return. The emotional intensity during arousal and the spasms of emotional release during orgasm are restrained through this rigidity. Interestingly, some persons release their emotional tension *after* orgasm, through

spasms of sobbing or laughter. This is another way to let go, but it seems preferable to experience a voluptuous kind of emotional intensity during sex instead of a tearful one after. The upper swing movement of the arousal mode in waves can accomplish this. It is often somewhat harder to learn than the pelvic swing. A person having acquired the double (upper and pelvic) swing movement during sexual arousal will find both solitary and partnered sexual experiences to be of a greater physical and emotional intensity. In particular, feelings of relatedness with the partner, self confidence and masculinity/femininity are enhanced, and the whole sexual act is perceived as sensually pleasurable, not just its culmination in orgasm (Bischof-Campbell, 2012).

3. The cognitive components of sexual pleasure

The way you think about a sensual experience, the ability to give positive meaning to it, is a key cognitive component of pleasure (Leknes 2008). Cognitions have powerful top-down regulatory ways to amplify or dampen pleasure (Kringelbach 2009). Imagine sitting in a movie theatre with your aspired future love, and the mere coincidental touch of your desired one's arm sends shivers of excitement and promise down your spine. The same touch by a random but repulsive seat neighbor will not only have a different meaning, but will *feel* differently and cause other neurovegetative reactions. Behind this lies an unconscious decision process of how to subjectively interpret the situation, based on a certain knowledge about the possible threats and rewards of this experience. Such learned cognitions regarding sexuality include explicit cognitive predictions such as messages conveyed by the parents, as well as implicit, not necessarily conscious knowledge. Knowing that genital stimulation feels good is mostly due to simple associative conditioning: the repetitive experience of positive sensorial input leads to positive reinforcement. Simply put, experience teaches me that something, i.e. masturbation, is good for me. Infants, as we have seen, work on this cognition from early on. Cognitions, furthermore, also elicit their influence through beliefs that aren't based on experience, as we know from the placebo-effect: it suffices to "believe" or "trust" something will be good for me, and reward mechanisms in the brain are put into action linked with the expectation *and the experience* of benefit (Esch and Stefano, 2005). Conversely, believing something is bad for me can elicit an unsavory experience. As in many societies knowledge and beliefs regarding sexuality are skewed, messages about sexual pleasure tend to be more of an aversive or punitive rather than an encouraging nature. The expectation of shame or punishment interferes with giving positive meaning to the experience of sexual pleasure. Commonly, clients experiencing problems with sexual pleasure have great shame or just can't picture themselves as sexually fulfilled individuals. Importantly, persons using the archaic or a narrow mechanical arousal mode are more likely to struggle with feelings of guilt and negative cognitions about sex than persons with a moving mode. In the Swiss study, sexual assertiveness and pride about their own genitals were directly linked with the amount of movement and variation the women used during sexual arousal (Bischof-Campbell 2012).

In therapy, cognitive approaches giving information and permission alone often are not sufficiently effective in breaking through the barrage of negative beliefs that may have been acquired very early in life. Therefore, in addition, Sexocorporel treatment strategies focus on inducing sensual experiences that trigger positive physiological reactions and thus induce positive cognitions. The repetitive experience of pleasurable sexual arousal challenges and is likely to modify negative beliefs. We invite the client to

repeatedly practice conscious and varied genital stimulation along with the double swing during autoerotic activities. Invariably, clients find their negative cognitions dwindling. The personal physical experience of “nothing bad happening”, and the triggered reward system convey a far more powerful message than the most sophisticated arguments of the gifted therapist: this feels good, therefore it is good.

In summary, Sexocorporel sexual therapy makes use of the unity of body and mind by influencing perceptions, emotions and cognitions through somatic modifications. It is aware of the existence of different sexual arousal modes – acquired patterns with profound consequences for the experience of sexual pleasure. It makes use of the plasticity of the brain by inducing new stimulation and movement patterns (the double swing). Based on a concise clinical evaluation of all physiological, emotional, cognitive and relational components comprising a client’s sexuality, therapy promotes sexual pleasure by inducing individually adapted variations in stimulation, movement, muscle tension and breathing that lead to a greater sensual hedonic input, a greater emotional intensity and release, and a greater ability to give positive meaning to a sexual experience.

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