An Overview of the Causes of Sexual Problems through the Lens of Ego Defense Mechanisms and Attachment Theory

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Abstract

Nearly half of the people in committed relationships who are surveyed report dissatisfaction in the areas of sexual intimacy, and this impacts how couples feel about their relationship. These findings indicate that this is an overlooked area in marital relations. This paper starts with a consideration of five different sexual dysfunctions as described in the DSM-V. A brief overview of hypoactive sexual desire disorder is presented, followed by an alternative interpretation based on Asian energetic views. Next, using ego defense theory and attachment theory as explanatory “lenses”, the paper reviews empirical research linking these theories to sexual dysfunction in couples. It posits that commonly reported sexual problems are often more than physical, that they have a potent psychological component, and that ego defense theory and adult attachment theory offer valuable insights into both their causes and possible solutions.
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An Overview of the Causes of Sexual Problems through the Lens of Ego Defense Mechanisms and Attachment Theory

Sexual dysfunction is a commonly reported problem for couples. In this paper, two sexual disorders will be considered, two for each sex, as drawn from the DSM-V, followed by an examination of hypoactive sexual desire. Let me say at the outset, that trying to understand the mystery of sex, intimacy and commitment – the territory covered in this paper – is an inundating if not impossible task. There are experts with varying opinions who advance different theories about the causes of sexual dysfunction, oftentimes with research that supports her or his position. In this paper, I will first consider the DSM’s views of the most common sexual disorders and briefly present an alternative view based on Asian energetic views of sex. Then, using a revised psychodynamic view which incorporates Reich’s and Lowen’s theories of ego defense mechanisms and Bowlby’s attachment theory, I will set the stage for a discussion of how obstacles created by emotional wounds, the defense mechanisms, and attachment problems impacts sexual intimacy and sexual satisfaction.

For the second portion of my master’s project, I will create a couple’s workshop on sexual relations that will synthesize Reich’s and Lowen’s theories of psycho-emotional growth and healing and insights from adult attachment research, with Asian energetic views of the body, to propose a model whereby couples can cultivate a self-less, unified state of being leading to the experience of erotic energy and heightened intimacy. I will propose that this relational state can be achieved whether or not a couple’s sexual organs are “functional” by DSM standards, or whether or not a couple even has intercourse. For the purpose of this paper, I will call it the energetic view. An important caveat: I recognize that sex roles are currently under transition now due to the increased attention to the sex lives of GLBT couples. For the purposes of this
paper, I am focusing on heterosexual relationships only. The ideas herein may be relevant to GLBT couples, but that is a topic for further study.

The Importance of Sex

Sex, Intimacy and Love

Researcher and relationship theorist Robert Sternberg (1986) has proposed a “triangular” theory of love which provides a framework to understand the role sex plays within close relationships. Sternberg proposes that adult relational love can be broken down into three interlocking categories: intimacy, passion and commitment. According to Sternberg (p. 119), “The amount of love one experiences depends on the absolute strength of these three components, and the kind of love one experiences depends on their strength relative to each other.” Since sexual relations are one of the primary arenas wherein couples share experiences of passion and intimacy, then it can be surmised from a Sternbergian view, that sex plays a powerful role in love. Research cited below supports the idea that the frequency of sex for couples is correlated with satisfaction with their partners (Smith et al., 2011). It can also be proposed that the feelings and emotions invoked in sex create opportunities for couples to experience blockages and obstacles to intimacy and sexual pleasure, in light of defense mechanisms and attachment wounds (a topic addressed later in this paper). I turn next to an overview of the DSM’s sexual disorders.

Sexual Problems

Female Disorders

Of the female dysfunctions, the most frequently reported problems are desire and orgasmic dysfunction. According to research, desire difficulty occurs with the highest frequency, preceded by orgasm difficulty, closely followed by arousal problems, and lastly,
complications relating to sexual pain. In regards to the amount of time each problem persists, the majority of the cases reported lasted for at least several months, while a quarter of the cases continued for 6 months or more (Hayes, Bennett, Fairly, & Dennerstein, 2006).

In regards to the efficacy of sex therapy with women of the aforementioned dysfunctions, two types, genito-pelvic pain disorder, also referred to as vaginismus, and female orgasmic disorder, or anorgasmia, are the most studied and are those in which therapy has a more positive result (Pereira, Arias-Carrion, Machado, Nardi, & Silva, 2013).

According to the DSM-V, Genito-Pelvic Pain/Penetration Disorder or vaginismus, has diagnostic features consisting of pain and difficulty being penetrated. There may also be fear of the pain associated with penetration and the constriction of the muscles of the pelvic floor. To warrant this diagnosis, these symptoms need to be significant enough to interfere with a client’s normal life and be maintained for at least six months (American Psychiatric Association, 2013).

According to authors of the book, Healing Painful Sex, gynecologist Deborah Coady and psychotherapist, Nancy Fish (2011), vaginismus is primarily a physical problem, but with implications that go way beyond the bedroom. For example, if a woman is feeling physically ill from a migraine headache, it’s perfectly acceptable to call in sick to work. It’s different when there is so much pain in the vagina that sitting down and concentrating is not an option. This is not something most women can discuss with people. Subsequently, any pain associated with the vaginal area can cause a woman to feel isolated, ashamed and depressed.

Causes for vaginismus are varied and complex. This was the finding of two British researchers, Ward and Ogden (1994) who gave questionnaires to 89 women suffering from the disorder. The participant’s associated their diagnosed vaginal spasms with defensive responses born of childhood trauma, such as rape, surgery, or infection. Others linked their symptoms to a
need to separate from a controlling parent or to long-held beliefs, such as “sex is dangerous,” or “undignified.” The psychological effects of vaginismus on the participants varied as well, and ranged from low self-esteem to suicidal impulses. Ward and Ogden framed these responses in terms of strategies to “protect the self” (Ward & Ogden, 1994).

Anorgasmia, the absence of orgasm, is designated in the DSM-V as a female orgasmic disorder. Women who suffer from this problem either have trouble having an orgasm or experience a significant reduction in the force of orgasmic sensations. In order to achieve this diagnosis, symptoms must persist for approximately six months and they must cause substantial distress to the individual.

There are two types of anorgasmia based on the condition’s onset. One is primary, where the individual has never had an orgasm. The other is secondary, where an individual who was previously orgasmic has lost the ability to have an orgasm. There is also a wide gap of prevalence rates, from 10% to 42% of the population reporting the disorder. Many factors are cited as causes for the condition; even the broad-based notion of “culture” has been blamed (American Psychiatric Association, 2013). Similar to vaginismus, this disorder is believed to have both physiological and psychological causes depending on the individual case.

**Male Disorders**

On the male side of sexual disorders, premature (or early) ejaculation is relatively common (Kaplan, 1987). When ejaculation happens in 60 seconds or less after penetration it is considered premature (American Psychiatric Association, 2013). One physiological-based explanation holds that men are so engaged in their sexual encounter that they are unaware of their level of arousal. They fail to slow down and relax the pelvic floor (PC) muscles, key to
prolonging sex (Michaels & Johnson, 2014). Kaplan (1987) states that the disorder is usually simple to treat.

Erectile dysfunction, the other affliction many men complain about is technically the inability to achieve and sustain an erection when engaging in partnered sexual activities. Of the male disorders, this disorder has a prevalence rate that varies greatly with age. An estimated 2% of males under the age of 40-50 years report difficulties with erections. That number increases to 40%-50% for males over 60-70 years of age who complain of persistent erectile dysfunction (American Psychiatric Association, 2013). The causes for erectile disorder, in addition to being co-related to age, are believed to be many and potentially complex. The physiological causes include an anatomically debilitated penis, insufficient blood supply to the penis and a dysfunctional nervous system. In many sufferers, it may be correlated with high blood pressure and vascular disease (Michaels & Johnson, 2014). In some men, erectile dysfunction is a response to psychological issues and stressors. In this light, Kaplan (1987) notes that even when all the biological components are well functioning, many men need to be in a state of emotional calm for a normal erectile response to sex. In sum, similar to women suffering from vaginismus, male sexual dysfunction is believed to possess a physical and psychological component.

**Hypoactive Sexual Desire Disorder**

The old diagnostic terms for this disorder, “impotency” for males and “frigidity” for females are no longer in use by scholars and are generally frowned upon. They are considered outdated diagnostic categories in part because they suggest sexual stereotypes. Traditionally, male sexuality is often seen as an expression of power, so sexual problems implies weakness. Stereotypic female sexuality suggests emotional warmth, therefore women suffering from
dysfunctions were considered “cold” (Michaels & Johnson, 2014). Hypoactive sexual desire disorder (from here on, HSDD), is the currently used term.

Both males and females can be diagnosed with HSDD, but it is much more common in females than males. According to the DSM-V, where it is referred to as “female sexual interest/arousal disorder,” it is featured by a lack of interest in sex. This can include a reduction of sexual thoughts, decreased frequency of initiating sexual activity and unresponsiveness to sexual invitations. For men, HSDD is sometimes related to erectile dysfunction or ejaculatory concerns, but not always. For both men and women, a couple’s attitudes and preferences about sexual initiation play a role in the frequency and the intensity of desire for sex (American Psychiatric Association, 2013).

In regards to the importance of desire for overall sexual and relationship satisfaction, a group of Australian researchers, working within the Australian Longitudinal Study of Health and Relationships, received responses to their survey from 3,304 women and 3,240 men, between the ages of 16 to 64 years who were in committed heterosexual relationships. In a specific project relevant to the study of HSDD, the researchers had two objectives. First, they asked participants to think about the last twelve months and identify if they wanted more, less, or the same number of sexual encounters they had experienced during this period. The second objective was to gauge the degree to which desired frequency of sex was correlated with relationship satisfaction (Smith et al., 2011).

The results of the Australian study indicated that 58% of women and 46% of men were satisfied with their current regularity of sex. Interestingly, a lot of people are not satisfied with the frequency of sex in their close relationships! It also tells us that more men than women report being unsatisfied. Members of both sexes who reported being displeased with the
frequency of sex were also more likely to report overall decreased relationship satisfaction. In sum, frequency of sex has a clear impact on the perceived quality of the overall relationship for both men and women in this study.

One causal factor believed to effect HSDD is the length of time the couple had been in a relationship. Longevity in a relationship, claims best-selling author and couple’s therapist Esther Perel (2006), is not only a factor in the decrease in sexual frequency, but a cultural expectation for marriage and long-term relationships. These findings, taken together, claims Perel, has led to a self-fulfilling prophecy regarding the intensity and frequency of marital sex. The changes go from the wild, passionate sex that may or may not propel the initial stages of a romantic relationship to later stages of reduced desire. Over time, the commonly held belief is that the eroticism contained early in an intimate relationship will evolve into a love that is more stable and predictable and less fueled by desire (Perel, 2006).

Research supporting this view comes from neuroscience, which correlates these observed changes in romantic passion in long-term relationships to underlying biochemical shifts in the form of hormonal decreases in the brain’s “love” chemicals in abundance in the early stages of romantic-sexual relations. According to anthropologist and human behavior researcher, Helen Fisher (2000), the chemicals; norepineprine, dopamine and phenethylamine (PEA), present in the early stages of relationships, last approximately three years. As the relationship evolves into a more mature marital relationship, other biochemicals take over. For example, the “snuggling drug,” oxytocin (also present in the nervous systems of those in secure attachment relationships), which lasts longer, plays a more influential role over time (Fisher, 2000). The side effects of this maturing love-devotion, namely, deep friendship and mutual respect are often considered to be a natural and equal trade-off for erotic passion (Perel, 2006). This conjoining of brain chemistry
and desire provides further support for the idea that sexual function is fueled by both physical and psychological causes.

In response to the high number of women who report dissatisfaction with the frequency of sex and a decrease in sexual desire, the first female drugs designed to increase sexual desire, and therefore frequency of sexual relations, is making news. Two new drugs, Lybriodo and Lybridos are currently undergoing tests for FDA approval (Bergner, 2013). Unlike its male counterpart, Viagra, which works with accelerating blood flow to the arteries so the penis can become erect, these new drugs work directly on the female brain to increase libido. It is yet to be seen, however, whether biochemically increasing a woman’s libido will in turn result in greater intimacy, passion and commitment in close relationships in a Sternbergian sense. What can be concluded here, however, is that even from the level of brain chemistry, emotion – in this sense increased desire or libido – is understood to play a central role in satisfying sexual relations.

**Beyond the Physiological and Psychological: Asian Views of Desire and Sex**

Psychologist Douglas LaBier (2010) agrees with the distinctions Perel draws between stages of a relationship over time and changes to the sexual intensity a couple experiences, but takes the model farther by incorporating intriguing cross-cultural views drawn from Asia. He goes so far as to create distinctions between types of sexual relationships that he believes occur on different “planes of existence,” be it the physical, relational or spiritual realms. In doing so, he implies that the different stages of sex a couple experiences over time has an “evolutionary” quality to it, with the highest psycho-spiritual stages occurring later in the relationship.

LaBier designates the type of sex many couples have when they first get together and feel the pull of lust as, “Hook-Up Sex.” This type of sex is the most primal, is lacking relationship qualities and is explosive and arousing. Many people call it “just plain fucking” (2010). Next up
the evolutionary scale is “Marital Sex,” which is, in many people’s minds, the boring and uninspired sex that couples who are in committed relationships experience. This stage would be linked with HSDD and the decrease in desire. In terms of treatment options, these couples have an emotional attachment to one another and are usually devoted to improving their sex life, which makes them good candidates for therapy. The highest on the evolutionary scale, according to LaBier is “Making Love.” This type of sex incorporates mind, body and spiritual practices, including elements drawn from Yogic and Buddhist Tantra and Chinese Qi Gong. Enhanced energy flow between partners is experienced, and the making of a self-less, unified state is the goal. LaBier declares, “this form of sex broadens, deepens, expands and sustains arousal and positive tension between you and your partner” (LaBier, 2010 p. 4).

Sex therapist Marty Klein (2012), agrees with LaBier in a couple of ways while making some important psychological points. He reduces the centrality of the physical organs to good sex and supplants it with a more holistic approach that incorporates the couple’s psychological states and – like La Bier – includes a view of sex as an energy-sharing experience. He is critical of the overly physicalistic approach to treating sexual dysfunction that focuses on improving function of the organs: “[h]ow to articles and workshops don’t help people have better sex,” Klein declares:

People don’t need another [sexual] position. Their penis and vulva are fine. They’re just not having a quality experience. What helps most people is more of a sense of relaxation and comfort versus getting the genitalia to behave differently or better. If people don’t relax and enjoy themselves, then a wet vulva or a bunch of positions won’t help. People need to reshape the experience so they have more of a sense of movement of erotic energy. Sometimes that includes intercourse, sometimes not. (Dana, 2012)
Summary: Reshaping the Experience of Sex

Note in Klein’s critique the centrality of comfort, relaxation and the sharing of energy as key to satisfying sexual relations. Interestingly, the former two characteristics—comfort and relaxation—are linked both to the psychology of secure attachment relations and the physical, neurochemical shift in the brain toward stabilizing hormones in long term relationships. Note also the link to an energetic view of sexual relations as drawn from Asian vitalistic views. The value of Klein’s and La Bier’s approaches is that they offer a different model of how sexual relations in long term relationships change. Rather than a “loss” of physical function model built of a DSM-inspired view of sexual disorders and the attendant treatment of the genitalia, or a loss of libido and desire model drawn from neuroscience and marital self-report research showing their potential debilitating effects to sexual intimacy in long term relationships, the energetic model points toward horizons of sexual growth and holds the promise for both healing of emotional wounds and deeper intimacy.

Defense Mechanisms

A study of Sigmund Freud’s original writings on the topic of defense mechanisms in light of current views makes apparent that the definitions of and distinctions between the defenses have changed over time. Theories about how they emerge within the individual have evolved as well.

Among the many theories of the defenses, the most inclusive view is rooted in models of ego-psychology (Diehl et al., 2014). Researcher, psychiatrist and professor at Harvard Medical School, George Valliant (1986) endorses a revised psychodynamic view which asserts that although there is little information about how distinct defense styles are created, there is
agreement that defense mechanisms are unconsciously driven, involuntary reactions to perceived threats. According to Valliant, each defense includes five distinct features: a) they govern instincts and emotions; b) they are unconscious mechanisms; c) they are distinct entities; d) although they can indicate a major psychopathology, they can be altered; and e) they can be linked to health as well as pathology.

One way the theory of the defenses has altered over time is in revised thinking about their relation to developmental stages. Freud, for example, linked the emergence of specific defenses to one of his stages (e.g., phallic, oral, etc.) (Freud, 1924/1993). Anna Freud (1936), however, dissented from her father’s stage theory, insisting instead that individual differences play a larger role in terms of which of the defense reactions will be elicited and that the context also strongly impacts which defense is employed to deal with an ego threat.

More recent research that incorporates advances in developmental psychology suggests that how the defenses are used by individuals changes across the lifespan (Diehl et al., 2014). In an effort to examine the age-related correlation between the utilization of defense mechanisms, Diehl and associates (2014), conducted a study using a sample of 392 European adults. As an assessment tool they administered the California Psychological Inventory, a self-report instrument that among other things, assesses people’s psychological understanding of their own and other’s behavior. They found an age-related correlation between defense strategies and the more adaptive “coping defenses.” In sum, as people age and became more cognitively and emotionally sophisticated, their use of defense and coping strategies alter as well, toward greater complexity (Diehl et al., 2014).

Paul Lerner (1990), one of the creators of a scale currently used to assess defense systems, proposes that after Freud, the most dramatic change in the theory of defense arose in the
sexual experiences that began with the work of psychoanalyst Melanie Klein in the 1940’s and 1950’s. Object Relations Theory maintains the premise that infant experiences form the basis for how adults relate to others in their environment. Klein re-conceptualized ego defenses by indicating that such mechanisms not only control drives and affect, but impact intimate relationships with other people. Consequently, they affect the individual’s capacity to understand, organize and internalize relationships (Lerner, 1990).

This significant shift in theory indicated that defenses were no longer conceptualized solely as a internal “machinery” working to counter a particular conflict or impulse, as was valid for classical Freudian psychoanalysis. Instead, defenses were seen as part of a series of cognitive and relational patterns that are established in the context of relationships with others during one’s early life. Moreover, in the Klein approach, the purpose of the defenses are extended to include the protection of a person’s self-esteem, rather than only acting to protect a person from becoming conscious of ideas or thoughts that would create anxiety were they remembered (Cooper, 1998).

Several other researchers have re-conceptualized defenses, generating a number of far-reaching classifications and categorizations which make it difficult to establish clear distinctions (Blackman, 2004). Moreover, the linkage of the defenses to sexual behavior are not well-established in the literature, nor are they geared in a way to show a direct correlation to sexual intimacy. And, as is true with other features of Freudian theory, the scientific critique remains regarding the difficulty of establishing the defense mechanism’s objective validity and reliability (Lowen, 1975).

For the purposes of this paper, three common defenses, which according to sex therapist and researcher Gina Ogden (2008), are believed to surface in sexual relationships will be
explored. They are disassociation, denial and armoring. Each defense will be discussed in relation to their possible origin in childhood, their physical and personality components and how, in adulthood, they may operate in couples with sexual problems.

**Reich on the Defenses**

Wilhelm Reich, the radical psychiatrist and Sigmund Freud successor, took the principles of ego-defenses and developed them into what he called “character structure” (Reich, 1933/1945). Unlike the ego-defenses, an individual’s character structure was the result of social processes first experienced within the nuclear family (Corrington, 2003). In this way, Reich’s theory shares features of object relation theory. Reich proposed that “wounds” to the self were inflicted in early life. They may happen due to a hostile parent, or due to a lack of nurturing, or when a parent rejects a child’s natural expressiveness and creativity. The internalized wound becomes consolidated and “preserved” in the unconscious, as a part of the individual’s character structure. Thereafter, the defense becomes “an automatic mechanism independent of the conscious will” (Reich, 1933/1945, p. 154). It can potentially appear as a neurotic problem in every dimension of an individual’s functioning. By extension then, a defense-based neurotic problem would also disrupt normal sexual function.

Within the individual, these processes create what Reich called “character armoring.” He believed that in therapy, the client could dissolve the armor – or defenses – which would provoke the memory of the childhood experience that was the impetus for the blockage in the first place (Greenberg & Saffron, 1987).

Reich’s student, psychiatrist Alexander Lowen, took Reich’s work and developed a therapeutic system called Bioenergetics. This system combines psychoanalysis, Reich’s character defenses, and a decidedly physical component: subconscious muscle tension. In
regards to this latter feature, Lowen introduced the importance of “grounding the body” through contact with the feet and the legs, as a means of bringing a client’s conscious awareness into their body, and out of their thoughts (Lowen, 1975).

Both Reich and Lowen affirmed that sexuality is a basic function of the human body along with moving, feeling, breathing and other forms of physical self-expression (Good & Rabinowitz, 2001). Interestingly, Reich discovered that many of his patients expressed a terror of the desire for sexual pleasure, which he called “pleasure anxiety.” He noted that it appeared in individuals who had grown up with parents who, while hiding behind a mask of “righteous self-discipline” engaged in physical and emotional abuse. He also observed it in adults born into cold emotionless families where affection was often withheld as a form of punishment. Gina Ogden reports that Reich called these families “factories of repression.” They were, in effect, “training grounds for sexual dysfunction, disconnection, joylessness and violence” (Ogden, 2008, p. 150). Lowen underscores how defenses, within such an oppressive developmental environment, operate both as survival mechanisms and serve to restrict life and vitality (Lowen, 1975).

**The Three Defenses**

In accordance with a Reichian-Lowenian theory of the defenses as they relate to sexual behavior, the first defense discussed here is disassociation. Disassociation as a diagnosable disorder is described in the DSM-V as “a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior” (American Psychiatric Association, 2013, p. 291). The growing literature on disassociation points to trauma as the cause. Traumatic experiences can fracture the structure of the self, resulting in hypnotic-like states and compromised awareness of reality (Gavin, 2010).
During sex, dissociation can manifest as a tendency for an individual to drift in and out of conscious awareness resulting in an inability to be fully present. Such behavior might also indicate a weak emotional bond or a lack of attachment to the partner. However, dissociation is not always pathological or maladaptive. For example, it can be used adaptively to block out chronic pain. However, as G. Ogden (2008) points out, blocking pain can be a double-edged sword, reducing an individual’s ability to feel anything, including sexual ecstasy.

The second defense, denial, and more specifically, denial of reality, can serve as an adaptive mechanism to protect one’s values and beliefs from being corrupted. In its maladaptive form, denial distorts a person’s perceptions when faced with a traumatic situation. A simple analogy to describe denial would be of an ostrich burying its head in the sand when it’s threatened. Gerald Corey (2013) claims denial is the least complex of all ego-defenses in its basic blocking function. In a similar light, psychologist Phebe Cramer (1987) declares that denial is the most primal defense. In infancy, its purpose is to protect the immature child from harmful over-stimulation at a time when they are developmentally incapable of physically removing themselves or disengaging from an event.

As children grow older, the language of denial appears in commonly used phrases such as, “I’m not afraid,” and “It doesn’t hurt” (Cramer, 1987). Reich held that denial involves a process of self-negation. The child realizes that if their need causes them pain, then he or she will stop needing altogether. The capacity for desire is diminished in the process (Blanck, & Blanck, 1974).

In adulthood, denial occurs when a person ignores past or present memories or experiences that are unpleasant or too difficult to accept. Instead, as a defense, the attention shifts to innocuous things (Diehl et al., 2014). In the context of sexual relationships, G. Ogden
(2008) proposes that denial serves several functions. It can serve to disconnect people from remembering an abusive and traumatic history they’d prefer to forget – which could be elicited in a close emotional relationship. From this angle, denial can be used to avoid the emotions elicited in intimate contact or sexual pleasure if those experiences provoke a traumatic memory or abuse the person would prefer to forget. It could also manifest in a belief that the minimal pleasure an individual receives from engaging in sex is normal. Finally, in more extreme cases, it might appear as a denial that sex is important and could manifest as a denial that sexual desire even exists.

The third defense in the Reichian-Lowenian framework is armoring which, according to Lowen (1975) manifests as a pattern of muscular tension in the body. Much like a suit of armor, this tension serves to protect the individual from threatening and painful emotional experiences or from the aggression of others. The armor also shields the individual from their own harmful impulses (Lowen, 1975). The origins of armoring, according to Lowen (1958) is in childhood and is linked to the experience of love, early erotic feelings and developing sexuality. As the child enters into adolescence and begins to sexually mature, the parent of the opposite sex – who previously had been affectionate and available – pulls their physical affection away. References to “Daddy’s little girl” and “Mommy’s big man” disappear. Since the child/early adolescent is still immature in their understanding and is unable to differentiate between love, erotic pleasure and sexuality, they experience this as a rejection by their parent. The side effect of the rejection is a blow to their capacity for sensual and sexual feeling. To compensate for this rejection, the child resolves to control all the emotions involved with this rejection – the rage and the pain, but also the positive feelings of emerging sexuality – by holding them back (Lowen, 1958). As this defense is woven into the ego structure, it manifests as ongoing issues of control, and as a
preoccupation with a prideful presentation of self and to never “look bad.” Although Gina Ogden (2008) prefers to call this defense, “armoring” it is not to be confused with Reich’s more global defensive formation “character armoring.”

Not surprisingly, an individual with this defense has a tendency to hold themselves stiff, like the Tin Man in the Wizard of Oz. They place tough restrictions on their own behavior, resulting in a guardedness. In terms of sex, these tin men and women will tend to compulsively hold back on their erotic impulses and be unable to “let go” during orgasm and surrender to their pleasure instincts (Lowen, 1975).

Lowen (1975) emphasized the importance of understanding nonverbal communication or what he called, “the language of the body” to probe the mind-body character of the defenses. For example, when a person tries to mask their feelings with an artificial postural attitude, their body belies the hidden truth by way of the prevalence of tension. Lowen points out that “telling a lie creates a state of body tension that is reflected in blood pressure, pulse rate and the electrical conductance of the skin” (Lowen, 1975, p. 100), (hence the lie detector test). A bioenergetic example of armoring in terms of mind/body connections and its effect on sexuality appears in a pattern of an “armored” person’s muscle tension. Such people, according to Lowen, can quite literally be tight-assed or choke-necked. Under such tension, it is impossible for them to have gratifying sexual relations because they are incapable of letting go into feelings of intense sexual pleasure for fear of looking foolish (Lowen, 1975).

G. Ogden (2008) claims that armoring can make it impossible for an individual to make genuine contact or bond with a sexual partner since the defense inhibits the expression of feelings, so essential to intimacy. Muscle or layers of fat can also help maintain emotional boundaries. Pleasurable sex between armored couples is simply an impossibility (Ogden, 2008).
Research findings addressing obstacles to healthy marital relationships dovetails with the effects of armoring in relationships. Although not identified as an ego-defense, and not direct heirs to Reich/Lowen lineage, famed relationship researchers John and Julie Gottman have developed the concept of “stonewalling” (Gottman, 1998). Stonewalling is a defensive response which occurs when a member of a couple emotionally removes or withdraws from their partner. According to their research, 85 percent of stonewallers are men. During a confrontation, when the man employs stonewalling as a defense, his pulse rate and blood pressure is likely to rise indicating – in a Lowenian sense – that there is a physiological dimension operating in stonewalling, as well. The implications are serious: once either spouse becomes a chronic stonewaller, the marriage becomes volatile and the fate of the relationship is unpredictable without intervention. In regards to sexual intimacy, stress and tension becomes so prevalent that couples refrain from interacting altogether (Gottman, 1998).

**Summary: Defense Mechanisms**

When it comes to the use of defense mechanisms, there is a physicality and a palpability to them. For example, when a person is disassociating during sex, they can feel distracted and disembodied. When a person is in denial about their sex life with their partner and acts as though it’s “fine” when it’s not, or that it “doesn’t matter” when it does, there’s a dissonance that occurs as physical intimacy and sexual pleasure are avoided. Lastly, when a person is armoring during sex, there is a lack of physical intensity and sexual ecstasy, which is replaced by physical stress and tension. What these defense mechanisms all have in common is their role in keeping couples sexually dissatisfied and insecurely attached.
Attachment and Intimate Sexual Relationships

This portion of my paper will explore how the attachment relationship is a core feature of adult intimate bonds. It will begin by providing an overview of founding attachment theorist John Bowlby’s (1969) ideas, with a brief discussion of research supporting the theory. In the second portion of the paper, how the attachment relationship has been applied to understanding adult relationships will be considered, with a focus on how insights drawn from adult attachment can be applied to help increase a couple’s sexual satisfaction.

Infant-Caregiver Attachment

In addition to her influence on the re-conceptualization of ego defenses through object relations theory, psychoanalyst Melanie Klein’s work had a major influence on the work of Bowlby (1969). Object relations theory, however is just one element in Bowlby’s theory, which incorporates instinct, drive and motivation theories amongst other theoretical constructs.

According to Bowlby, attachment is a biologically based system that helps vulnerable infant mammals form attachments to their caregivers to help them survive. Healthy attachment in humans is formed when caregivers provide consistent, responsive caregiving leading to feelings of security in infants. But Bowlby went much farther, proposing that attachment was an innovative way to understand aspects of personality in human beings. In his view, Freud and virtually all successive analysts approached the dynamics of personality by working backwards, beginning from the time the client’s personality was more or less developed and then through psychoanalysis, “reverse engineering” the phases of personality. Primary observations, obtained in the analytic setting are traced to their origins and interpreted according to the attendant effects on the client’s psychology, behavior and psychopathology (Bowlby, 1969).
Attachment, according to Bowlby, operates in a more developmental manner. Primary data are drawn by carefully observing how infants and young children operate in defined situations with an eye toward what kinds of experiences expose the quality of the relationship between infant and caregiver. Such observations led Bowlby to conclude that the need for security was a key feature driving the formation of attachment bonds and anxiety and insecurity were the by-product of poor attachment. Secure attachments, from both a biological and emotional view, would yield the best adaptation for infants and young children. Bowlby draws a distinction, however, between secure attachment and being free from harm, i.e. attachment is not a measure of relative safety; rather it is about the quality of the relationship between caregiver and vulnerable infant (Bowlby, 1973).

Bowlby’s clinical observations and theoretical work have found support in empirical research. Mary Ainsworth (1985) applied attachment theory to the study of infants interacting with their caregivers and in the process created an assessment tool – the “strange situation.” The purpose of the 20-minute laboratory assessment is to alternately stress and give solace to an infant by sequentially allowing the infant to interact with their primary caregiver (usually his or her mother), to encounter a stranger, to be separated from the caregiver, and then to be reunited with her. How the infant interacts with their caregiver and the stranger, how curious s/he is of the novel environment, how able the caregiver is to settle a distressed infant when they are reunited after separation are some of the key observations made which reveal the quality of the attachment relationship.

Ainsworth (1985) concluded that there are four basic patterns of attachment behavior in infants, as follows:
1) Secure attachment- An infant is securely attached when s/he cries and protests when her mother leaves the strange situation room, welcomes her upon her return and is subsequently calmed by contact with her. Ainsworth noted that the caregivers of securely attached infants were “sensitively responsive to their [infant’s] signals” (Ainsworth, 1985 p. 28).

There are two types of insecure attachment, anxious-avoidant and anxious resistant (or ambivalent).

2) Anxious-avoidant - These children show little emotion if the caregiver leaves or returns to the room. It is believed to be the product of a caregiver who has not been sufficiently emotionally available or responsive to the infant’s signals and need for comfort.

3) Anxious – resistant (also called ambivalent attachment.) These children become greatly distressed when the caregiver leaves the room, but ambivalent when the caregiver returns. Ainsworth proposes that it is a product of a caregiver who has not been consistently responsive to the infant’s signals for contact, creating a sense of ambivalence in the infant toward her caregiver.

4) Disorganized/disoriented attachment- Ainsworth and her colleague, Mary Main later added this fourth classification. There is a deficit of attachment behavior in these infants. This occurs when caregivers have been particularly unpredictable in their caregiving, so there is no organization to the infant’s attachment behavior, and the infant is often consumed with fright and even terror (Firestone, 2013). Firestone (2013) claims that there is a link between disorganized attachment and the ego-defense of disassociation. “When a parent or caregiver is abusive,” Firestone claims, “the child may experience the physical and emotional abuse and scary behavior as being life-threatening. The child is stuck in an awful dilemma: her survival instincts tell her to flee to safety, but safety may be in the very person who is frightening her.” An abusive
attachment figure becomes a source of trauma for the child, leading to disassociation from their selves, with its attendant blocking of consciousness of the traumatic material (Firestone, 2013, p. 1).

Bowlby’s hypothesis, that the quality of infant-caregiver attachment would impact later development has been borne out in empirical research. Longitudinal research, in particular, has shown that the quality of early infant-caregiver attachment influences the character of the child’s later relationships (Sroufe & Fleeson, 1986). These findings, and correlations of attachment to other features of development as discovered from empirically-based research has been influential in terms of thinking about how individuals adapt to their social worlds and the origins of psychopathology (Sroufe et al., 2005). The next step was to begin to think about how attachment behaviors play out in intimate adult relationships.

**Adult Attachment and Intimacy**

Cindy Hazen and Philip Shaver (1987) were some of the first researchers to extend attachment theory to adults. They obtained their data by formatting a questionnaire they called a “love quiz” and had it printed in a local newspaper. It was printed in a highly visible section of the paper and referred to on the paper’s front page with a banner headline that read “Tell us about the love of your life; experts ask 95 questions about your most important romance.” (Hazen & Shaver, 1987, p. 514). They used the first three categories of attachment behavior manifesting in infancy and applied them to adult relationships:

1. **Secure**— Securely attached adults view themselves, their partners and their relationships positively. Overall, they are satisfied with the quality of intimacy and closeness they experience.
2. Avoidant- These individuals demand a high level of independence and may avoid becoming attached to others. Their views on love were more “sobering” and did not believe in the commonly held romantic notions of love.

3. Anxious/Ambivalent- These individuals in relationship are capable of high levels of intimacy; they seek approval from their partners and are overly dependent on them. They reported that it was “easy for them to fall in love although they rarely find what they call real love” (Hazen & Shaver, 1987, p. 515).

The results supported the authors’ original hypothesis, that the three attachment styles, secure, avoidant and anxious/ambivalent were nearly “the same in adulthood as [they were] in infancy” (Hazen & Shaver, 1987, p. 511).

Also, the data supported the hypothesis that people in the three attachment categories experience love differently. They hold different beliefs about romantic love, the accessibility and trustworthiness of their partner’s affections and their own self worth. Attachment orientations entertain different beliefs about the course of romantic love, the availability and trustworthiness of their partners and their own self-worth.

An important qualification made by Hazen and Shaver (1987), however, is that attachment patterns in adults are flexibly organized, in the sense that individuals will express different adult attachment behaviors for different relationships. Not only does this suggest flexibility, but that the character of intimacy a couple shares will be shaped by attachment expectations each of the partners brings to the relationship. Research on attachment conducted by Susan Johnson and her colleagues at the Center for Emotionally Focused Therapy (Caron, Lafontaine, Bureau, Levesque, & Johnson, 2012) supports this idea, that adult attachment must be understood in context, as opposed to a trait possessed by an individual who carries it across
A possible interpretation of this claim is that from a therapeutic standpoint, there is workability in regards to establishing a secure attachment between adults. Attachment is a relational pattern. It is not necessary to try to change a personality or alter a trait to make improvements. This interpretation can give hope to couples struggling with issues of intimacy including those surrounding sexual dysfunction. Therapists can honestly inform couples that there is a light at the end of the tunnel when it comes to working with sexual issues which have an attachment component.

Not surprising, that the field of couple’s therapy is recognizing the relevance of attachment theory as a core variable in adult bonding relationships (Johnson & Greenman, 2013). Over the length of a close relationship, satisfaction can fluctuate for many reasons and in many ways. Insights from attachment theory show us that regardless of age, the calming effect of close contact with a loved attachment figure triggers valuable feelings of security and comfort. This may explain findings linking feelings of secure attachment to improved physical and mental health (Johnson & Greenman, 2013; Sroufe, et al., 2005).

According to researchers Peloquin, Brassard, Lafontaine and Shaver (2014), a number of studies have shown a positive link between adult attachment style and the functional quality of romantic relationships. However, there has yet to be a study that has directly investigated sexual satisfaction that is grounded in attachment theory. There certainly is a need for knowledge here. Fifty percent of adults in the mainstream population report sexual dissatisfaction (Laumann, Gagnon, Micheal, & Michaels, 1994, as cited in Peloquin, Brassard, Lafontaine & Shaver, 2014, p. 561), and greater than 60% of couples entering couples therapy report significant sexual
distress in addition to other relationship problems (Brassard, Peloquin, Dupuy, Wright & Shaver, 2012, as cited in Peloquin, Brassard, Lafontaine, & Shaver, 2014, p. 561). Given these statistics, it is unfortunate that many psychotherapists fail to blend attachment theory with sexual assessment and treatment planning in couple’s therapy. McCarthy and Thstrup (2008) attribute this to the fact that the professions of sex therapy and couple therapy have evolved separately, creating additional conceptual obstacles to adjoining attachment and sex. The reason for this occurrence is that many psychotherapists feel awkward working with sexual problems (Byers, 2011, as cited in Peloquin, Brassard, Lafontaine, & Shaver, 2014, p. 562) and instead rely on the couples’ work on other aspects of their relationship to naturally improve their sexual satisfaction (McCarthy & Thstrup, 2008, as cited in Peloquin, Brassard, Lafontaine & Shaver, 2014, p. 562).

In a study designed to connect the dots between the relational and sexual facets of couple functioning, researchers Peloquin, Brassard, Lafontaine, & Shaver (2014), used adult attachment theory as a basis for their analysis. Their goal was to consider which aspects of a partners’ romantic attachment is associated with general sexual satisfaction as expressed by both partners. The researchers used facets of a couples’ caregiving behavior (e.g., proximity, sensitivity, control, and compulsive caregiving) to study whether these aspects mediated the relationship between their attachment uncertainties (anxiety and avoidance) along with the reported sexual satisfaction of both partners. This information was procured through questionnaires. The results of this study showed that caregiving proximity mediated the relationship between attachment insecurities and a couples’ sexual satisfaction (Peloquin, Brassard, Lafontaine, & Shaver, 2014). Caregiving proximity is best understood by the question given to participants from the Caregiving Questionnaire, “when my partner seems to want or need a hug, I’m glad to provide

The researchers concluded that this attachment measure, caregiving proximity, “might be a core component of romantic relationships, lying at the juncture of the attachment, caregiving and sexual behavior systems” (Peloquin Brassard, Lafontaine, & Shaver, 2014, p. 573).

Summary: Attachment

A key proposition in attachment theory is that secure attachments between infants and their caregivers and between adult romantic partners is correlated with the best adaptations in terms of intimacy and comfort levels. Attachment theory as applied to adult relationships indicates that attachment is a relational pattern and not a personality trait and that adult attachment patterns are flexibly organized and therefore different relationships may invoke different attachment patterns. Researchers have uncovered evidence suggesting that the quality of the adult attachment relationship is linked to sexual satisfaction. Not surprising, that the field of couple’s therapy is gradually acknowledging that attachment is a major tenant in adult intimate relationships. Given these findings, we can conclude that attachment patterns, like the ego defenses, impact a couple’s experience of sexual intimacy and sexual satisfaction.

Conclusion

In this paper, I have adopted the view that sexual problems are relationship problems. Instead of viewing sexual dysfunction as merely a performance problem and searching for a cure based on physical mechanics or chemistry, a deeper understanding is required. Both the individualized development of the ego defenses and attachment styles are essential to understanding couple’s sexual problems. Both can operate to create blockages in the expression of sexual desire and erect obstacles to intimacy.
The psychoanalytic view employed in this paper sees the defense mechanisms as arising from childhood woundings and represent coping mechanisms. Different attachment styles are similar in that they are adaptations to the availability of feelings of security and care in relationships. Together, they point to the possibility that woundings and relational patterns, when better understood, can be both a vehicle for personal growth and can stimulate the evolution of a couple’s relationship. Once this healing takes place and the growth occurs, the possibility is there that a couple can create a different type of sexual relationship that is more intimate and fulfilling. This “mature love” has the potential for a comfort and warmth and may even be characterized by the melting or merging with one’s partner. It also has the potential to release potent forms of desire, an “erotic force” that can lead to new horizons of love and intimacy.

Before proceeding, one insight learned from my study is the importance of closing the gap that currently exists between sex therapy and couples counseling. At the time of this writing, a course in human sexuality is not required for state licensure in marriage and family therapy programs. A good start, in my opinion is to reintroduce such a course in MFT programs.

I turn next to a technique manual designed for a hypothetical couple in a weekend workshop. These techniques are designed as therapeutic processes that couples can practice to increase their sexual desire so they can have a more satisfying sex life, release their ego defenses and create a more secure attachment.
References


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