Part IV

Sexual disorders

15. Sexual aggression disorders

We are not going to deal with sexual disorders from the point of view of the DSM. In this paragraph we are to analyse what happens when sexual aggression is disturbed. In fact, sexual disorders often derive from the difficulty of combining the need for exchange, intimacy, fusion and pleasure with the need to assert oneself as an individual, rejecting the other's behaviour that can be harmful and confronting oneself with the other's diversity.
As we have seen, love and sexuality need to be sustained against a ground of conscious aggression in order to be able to express themselves safely. Aggression, for its part, needs a background of love and sexuality in order not to exceed in destructiveness. The inability to integrate these two polarities in a dynamic figure/ground relationship often results in the emergence of defensive or destructive behaviour that manifests itself at times of encounter and/or abandonment, i.e. when the person feels most vulnerable and exposed.
Therefore, we want to make it clear that any disorders of the sexual sphere will be addressed in relational terms. This is not to say that there are no sexual disorders dependent on individual physiological motivations, but in our experience the incidence of the latter is very low, compared to the large number of sexual disorders linked to problems in the couple and/or the broader field that includes families of origin, childhood and adolescent experiences.
In other words, sexual disorders are always the expression of a survival strategy that derives its effectiveness from the very behaviour we call a 'symptom'. In Gestalt therapy, we say that there are no disorders, only 'stimuli'.
What does that mean?
With the term *disorder* we give a negative value to an event that distracts us from a task.
The disorder can be an obstacle or, on the contrary, a stimulus that – by bringing out the conflict between two intentionalities (original and substitute) – represents a useful signal to orient ourselves and bring out the original intentionality. Thus, it represents an obstacle for the substitute intentionality, while it is an 'opportunity' for the original one.
An example. If I have chosen a faculty that I do not like just to please my parents (substitute intentionality) and am preparing for an examination that does not interest me, a dog barking a kilometre away will be an unbearable disturbance. In this case the original intentionality is to assert myself in front of my parents as an adult, autonomous and responsible person. The dog disturbs the substitute intentionality of relating to my parents on the basis of introjections. If, on the other hand, I am involved in exchanging effusions with a lover, I will probably not perceive a single note of the rock concert going on around us, as I am fully myself on the contact boundary.
Perls and Goodman (1951) spoke of symptoms in the terms of 'creative adaptations' because, if the individual does not have the support to carry the original intentionality through to the end, then the substitute intentionality represents the best compromise to exploit the available supports. This creative strategy is limited but nevertheless the best possible in that field. Therapy is precisely a way to broaden the possibilities and support of the individual, who in a different 'situation' (Robine, 1995) will behave and be a different person. According to this field perspective, disorders are not individual, but are the expression of the ongoing relational situation (Francesetti, Gecele and Roubal, 2014).
The sexual disorder thus tells us that a conflict between intentionality is active and, at this moment, is emerging at the surface. It is therefore a stimulus to recognise what is the original intentionality that I, or rather, the couple, is denying.

1. Lack of desire

It is *probably* the most widespread sexual disorder. *Probably* because the statistics are missing that segment of the population that does not accuse it as a disorder, but considers it normal.
Lack of desire often presents itself with very different characteristics. Let us look at some of them.

A. Lack of desire can be expressed, for example, by both people in a long-term couple. In our Eurocentric culture, it is considered normal for a couple that has been together for twenty years or more to experience a drastic drop in sexual desire. I believe that this cultural confluence also depends on viewing sexuality through the filter of religious morality. If the purpose of sexuality is reproduction, it is 'normal' that people who have been together for twenty years or more, with the age of the partners being around 50, no longer have sex,

because a couple of this age is unlikely to want or be able to have children.
But if we step outside the reproductive logic and recognise sexuality with its power to unite, create intimacy, closeness and care, we should ask ourselves why these characteristics are no longer important as time passes.
Actually, there is no reason for a decline in sexual desire with the passage of time, other than the characteristics of arousal and sexual desire.
As we have already said, sexuality is a contact phenomenon and as such it needs novelty in order to develop and grow to fullness. As the PHG tells us: *no repetitive phenomenon can be the object of contact*.
In fact, it is the duration in time and not the age of the partners that influences the decline and lack of desire.
When we start a new relationship the desire and excitement between partners is usually very high regardless of age. The novelty of the situation, combined with insecurity, fear of losing the other person, the desire to conquer, this mix of novelty, attraction and fear, create a very high level of excitement.
Then the couple begins to be together. If planning is not developed, the novelty and fear of losing the other diminish and the attraction with it. The excitement gradually wanes and people break up. But if a planning together is developed, it brings elements of novelty linked to the realisation of projects and the couple builds superstructures and bonds of responsibility, interest and love, such as children, marriage, the purchase of goods, work and/or cultural and/or social undertakings, which make people want to be together again as a couple even if the sexual desire is diminished.
Desire wanes because the other person is more and more familiar, more predictable, ultimately becoming taken for granted. This causes a gradual increase in security in the relationship and a corresponding decrease in novelty and thus excitement and contact. Sexuality is reduced to a minimum or even disappears.
The couple misses it but considers it normal.
It is normal, but not inevitable.
In order to rekindle desire, elements of novelty and insecurity must be introduced into the relationship.
It is common for couples with long extinguished desire and sexuality to suddenly find arousal and desire again if one of them confesses to an extramarital affair.
Novelty and moderate danger, these are the elements that support a satisfying sexuality.
However, as Proust used to say, one does not have to look for new landscapes, but to have new eyes. It is therefore not necessary to have extra-marital affairs, even though these can be part of a search for new experiences in the couple, as we shall see when discussing paraphilias: in order to create novelty, we must first be aware of its importance.
In order to see the other person with new eyes and for the other person to be able to do the same, one must first *accept the risk of losing him/her*. If the other is too sure, he/she becomes taken for granted, i.e. loses value.
Accepting to run the risk of losing does not mean going away or giving up, it means to maintain a sufficient level of separation, aggression, identification in the relationship that allows us to preserve our friendships and our spaces, to develop autonomous projects from which the other person does not necessarily need to be excluded, but which remain for him/her spaces of novelty, surprise, discovery of unknown parts of us. Mystery is intriguing. When it becomes too much, i.e. when it generates exclusion, estrangement and rejection, then it becomes threatening and generates anxiety. But if it is appealing without showing everything, if it invites to the discovery and the research, then it becomes exciting.

B. Lack of desire is only expressed by one of the two persons. This phenomenon has very different characteristics from the previous one.
Typically, it is manifested by women towards men, but now that relationships are becoming more equal it is also manifested in men and in gay/lesbian couples.
With respect to women H. Kaplan does not speak of frigidity, but of 'general sexual inhibition'. In the triphasic conception of the sexual response (Kaplan, 1974), the lack of desire and the impotence are linked to the phase of desire and arousal, in which at least four different types of women would fall:

1. those with an aversion to sexuality;
2. those who do not feel sexual sensations in any part of the body;
3. those who derive pleasure from physical contact but not in the form of genital eroticism;
4. those who only suffer from a lack of responsiveness to stimulus or have difficulty becoming sexually aroused.

Frigidity is a disturbance when the woman wants to experience sexuality but is unable to do so. In this case we speak of a fixed *gestalt*, i.e. an adaptation that reoccurs because the *original intentionality* is not achieved and the *substitutive* one is no longer sufficiently fulfilling.
The therapeutic work consists in bringing out these different intentionalities.

A clinical example is that of a patient who could not accept her desire for intimacy with the man she loved. An introject of this kind emerged quite early on: "*Sexuality is a dirty thing and men only want one thing*". The therapeutic work showed that this was the mother's bodily and implicit teaching, i.e. the mother's experience with men and not the patient's own experience. A change was possible when the woman recognised that her "I can't" was actually "I don't want to" that had its own good reasons: it was a form/request of love towards the mother. Experiencing sexuality as a dangerous affair was tantamount to agreeing with the mother's teaching, continuing to make her important. The inherent cost was to give up an important part of her life in which to be an adult woman and become herself. The need for maternal recognition emerged, i.e. the original intentionality, which competed with the intentionality developed as an adult to have an intimate relationship. *The patient discovered that frigidity (substitute intentionality) was the creative way in which she could remain attached to her mother and, at the same time, be with her partner. Frigidity, moreover, is a field solution, i.e. it emerges in a relational field that somehow supports it*. Once she regained a real sense of her power, she then realised that what she was interested in was regaining her sex life in all its fullness and that she could no longer love her mother as a child, but as an adult.

In other cases, frigidity is not a disorder and, for all intents and purposes, does not disturb the balance of life. In this event it presents itself as a situation in which the person alienates herself and is not interested in sexual experiences, as is the case with those who choose asexuality. The intentionality that emerges is to encounter the world on other planes (affective, amicable, intellectual, etc.) and asexuality can be experienced in an energised existence.

In Gestalt therapy, we do not have the idea of the patient as an inept and incapable being, but as endowed with power that she/he uses in a way that will generate some costs for her/him. On the other hand, all choices have their consequences, both on a neurotic and on a conscious level.

In the contact cycle of Gestalt therapy, lack of desire, together with erectile or lubricatory impotence, are part of the pre-contact phase.

From a neurological point of view, according to Kaplan these dysfunctions are linked to an intense emotional activation by the sympathetic nervous system, blocking the activation of the parasympathetic nervous system, which controls the reflex mechanism of blood pressure and genital vasodilation. *Fear, anger or guilt* interfere with the vascular reflexes that cause erection in the male and lubrication-swelling in the female.

The emotional activation is seen by Kaplan and by the cognitive-behavioural orientation as an 'interference' and this gives us the idea of a different epistemology from that of Gestalt therapy.

For Gestalt, *emotion is an immediate form of understanding the situation that is necessary for orientation*: in the example above, we saw how important it was to value the guilt and fear that the patient felt. *We do not work in idealistic terms, i.e. thinking that the fairest and healthiest thing is for her to recover her sexuality with her partner, for whom emotions are felt as an obstacle*. We therefore do not give prescriptions for idealistic goals[1] . Starting with the symptom and the emotions, we go on to find out *what the person is already doing, where she is already going and how she can do it without paying such high costs*. Once we have removed the obstacles that prevent her intentionality from flowing like a river, the patient will no longer need prescriptions and advice to recover the sexual pleasure.

In dealing with these survival strategies, the exploration of the field that made them effective is crucial. We could in no way identify ourselves in frigidity if not within a field that supports this type of creative solution. Let us see how.

If we look at the lack of desire (expressed by only one partner) from the point of view of the field, we are frequently confronted with an *imbalance within the relationship*. One of the two is becoming dominant over the other, who is experiencing objectification. It may be a dynamic that creates suffering and is at the root of this disorder, or it may be a vicious consequence that is created thereafter. Either way, it contributes to a suffering in the couple.

A typical example of dominance and objectification is when one partner asks the other to make love even though he/she realises that the latter shows no desire and then insists with phrases such as: "*You'll see that if you start, you'll like it*" or "*It's been a long time since we've done it, I need it*" or "*Do it for me"* or "*You can't leave me like this*". This last sentence is frequent when the partner loses desire during the sexual intercourse.

Asking another person to have sex even if they don't want to is asking them to make themselves an object and

[1] Occupational therapy involves 4 phases to which different tasks correspond: the aim of the first phase is to get to know oneself. It prescribes 1) the practice of self-observation of one's own body; 2) the Kegel exercise, i.e. a series of genital contractions aimed at recovering the use of the perineum; 3) the discovery of the point of orgasmic inevitability, i.e. the moment when the person can stop the growth of arousal. Subsequent phases prescribe sensory focalisation and are aimed at exploring one's own and others' pleasure, both diffuse and genital, in a non-exhaustive manner, i.e. not aimed at orgasmic discharge (Kaplan, 1974).

we become dominant.
Objects do not work from desire but from a programme, living beings act out of need or desire.
If I force myself to make love without feeling the desire but at the other's request, I make myself an object, because I deny my own sensations. It is also possible that by doing so, I will develop genital arousal and perhaps even hope for a form of orgasm, but the lack of desire will remain within us and will tend to increase our rejection of the other person.
We report a couple who came to therapy presenting the 'problem' of the wife's lack of desire. During the sessions it emerged how she experienced sexual intercourse as "*a time card that I have to punch out once a month*". Between intercourse, she used a whole series of strategies to refuse her husband's requests: headaches, tiredness, periods, children, but she knew that after about a month, she had to punch out, otherwise he would become more and more nervous and the atmosphere in the family would become very unpleasant.
This lack of desire has many traits in common with erectile or lubricatory impotence, which we will discuss later. The main difference is that, whereas in erectile or lubricatory impotence the person says he/she wants to have sex with the other person and "it is his penis/vagina that is not working", with lack of desire the person does not feel the desire, therefore, there is no internal split. There is a feeling which one can lean on.
The lack of desire is not a problem, but it is a solution that denounces what is happening in the couple. The fact that it is only expressed by one of the two does not mean that it is that person's problem, but only that this is the element through which the couple's suffering is being expressed. He/she is probably the element that is more sensitive or under more pressure or with a history that makes him/her experience of being objectified painful.
However, it is a solution that has its inevitable cost, i.e. it increases distance and fuels both a loss of empathy for the other, and a loss of sympathy, i.e. a desensitisation to what the other arouses in ourselves by his/her behaviour.
As we can see, Gestalt therapy has a very different vision from the cognitive-behavioural approach. For the latter, the symptom (lack of desire) is not the solution for the couple to stay together but is the problem to be eliminated through a strategic approach.
As for the case of the couple mentioned above, an important support was to let them experience the change of identification. Asking her to become him (and vice versa)[2] and inviting them to talk to each other while they were identified with the other supported the rediscovery of empathy and the appreciation of emotions such as shame, humiliation, fear of loss, devaluation and contempt. It also fostered an appreciation of the sympathetic process, i.e. the importance of telling the other person what their behaviour aroused, not in a reactive and rejecting way, but with care and attention to the vulnerability that the other person was expressing at the time. It was neither a quick nor an easy job.
Co-leading also gave us the opportunity to exchange our chairs of therapists with the patients' ones. We identified with both of them by moving to another possible way of being a couple, which was not better, nor conceptualised and not reached through an act but through an authentic process of identification that led us to explore our vulnerabilities, fears and resistances. Engaging them in a field of value, care and passion for what we are striving to do as a couple. Through anger, rejection, fear, mistakes, passion and desire. Being there for each other, in spite of everything.
If this desire to be there for each other does not emerge in the work with couples, the lack of desire may denounce a situation of co-dependency. That is, a situation in which I would like to detach myself from my partner who I recognise as being harmful to me, but I do not have the strength. I experience the fear of not being able to survive without him/her. In this case, the dynamics related to the lack of desire, objectification and surrender to the other's demands or violence, become a survival strategy that allows me, through a double-bond situation[3] in which I reject the other but then suffer him/her, to confirm my inability to be autonomous. In the latter situation, couples therapy can serve to make individual needs emerge and support people to embark

[2] Awareness of the process of identification and alienation is for Gestalt a key stage in the development of an adult self. In childhood games it occurs with the "Let's pretend that" and is a spontaneous process. In the adult it requires the ability to relativize one's own experience and to abandon the belief that there is only one reality and that is obviously the one I experienced. Being able to identify with the other person, to put oneself in his/her shoes, to imagine the world through his/her eyes and experience is often an important step in restarting a dialogue blocked by crystallised certainties.
[3] A double bond is a situation in which there is an appearance of choice but then, whatever choice is made, the result does not change. More frequently, it is another who puts us in a situation of double bonding. The classic example is that of the mother who gives her son two shirts and, when he wears one, says: "You don't like the other one". But we can also get ourselves into dead-end situations. In the example of co-dependency, if faced with a lack of desire the other respects rejection, the message becomes "I can do without you, you are worthless". If on the other hand he/she forces the other to have sex even if he/she does not feel like it, the message becomes "Only my desire counts, you are worthless". I am worth nothing, only you are worth is the classic experience of co-dependency.

on an individualised pathway that often ends in separation. At other times, transformative capacities will emerge and they will favour a return to couple-therapy which supports the emergence of a new relationship between the two people. In the above-mentioned example, the epistemology of Gestalt therapy clearly emerges: it works on the hermeneutic circle, explores individual experiences and continually brings them into play in the interaction, thus expanding the perceptual-relational field of both partners.

2. Erectile and lubricatory dysfunction

The term impotence is misleading, or rather, it is the classic example of a diagnosis that does not explain the problem but strongly contributes to creating it.
The phenomenon of penile erection in the male has its counterpart in the lubrication of the vagina in the woman. The use of artificial lubricants for the woman or other means of penetration for the man (rubber penis or fingers or other) may be a way of caring for the other, but it does not resolve the relational disorder represented by the difficulty in exchanging pleasurable genital sensations.
With regards to men, the erection is a vascular reflex connected to the autonomic nervous system. Therefore, it is very susceptible to the anxieties and fears experienced at the time of an sexual encounter. Impotence may be associated with a general loss of desire or an ejaculatory difficulty, but its essential characteristic is the impediment to the erectile reflex. In particular, the vascular reflex mechanism fails to pump enough blood into the corpora cavernosa of the penis to make it rigid and erect. The man may feel aroused and want to make love but cannot get the penis erect. The erectile and ejaculatory reflexes may be dissociated: in fact, some impotent men are able to ejaculate without having an erection.
What it seems then to 'jam' is the vasodilation mechanism, which is under the predominant control of the parasympathetic nervous system.
If vasodilation does not occur despite adequate stimulation, H. Kaplan hypothesises the presence of an inhibitory mechanism that blocks the reflex reaction (1974). For this to occur, it may be sufficient that the anticipation or initiation of the sexual intercourse leads to an intense emotional activation (anger, fear, disgust, etc.) such as to trigger an 'alarm reaction', which in evolutionary terms had the sense of preparing the animal for combat. The sympathetic activation sustaining the alarm reaction inhibits the prevalence of the parasympathetic one, which is necessary for the genital vasodilation and thus the arousal.
The mechanism of emotional inhibition of sexual arousal, however, has a clear evolutionary value. In the face of danger, it is not functional to occupy oneself with the proliferation and to increase one's vulnerability: instead, it is more appropriate to engage in an attack/escape behaviour that requires muscular, rather than genital, arousal.
In this sense, according to Fenelli and Lorenzini, we can hypothesise that arousal inhibition is also present in animals (while it is doubtful that the same can be said for orgasmic disturbances). The only difference being that in animals it cannot be regarded as a disturbance, but as a healthy safety mechanism for individual survival rewarded by evolution (Fenelli and Lorenzini, 2012).
Depending on how the dysfunction arises, two clinical categories can be identified: patients suffering from primary impotence have never been powerful with a partner, although they may have erections with masturbation and in some spontaneous situations. Patients with secondary impotence have 'functioned' properly up to a certain point before the problem arose. On the female side, sexual arousal consists of the dilation of the genital vascular apparatus, which is also under the control of the autonomic nervous system. The relaxation of the smooth muscles causes vasoconstriction, dilation of the vagina and upward displacement of the uterus. This kind of relaxation is a visceral reaction that is found not only in the reproductive system, but also in the digestive, respiratory and blood pressure regulating systems. Because they are regulated by the autonomic nervous system, these vegetative reactions are all subject to the emotional state. If the person is angry or distressed, the nervous system will devote itself to managing these emotions, rather than to digestion, producing, for example, a hypersecretion of acids and a spasm of the smooth muscles.
What we have said above should make it even more obvious that what we call 'disorder' is a highly refined survival strategy whose original intentionality we must try and understand.
Unlike men, women's capacity for arousal and the ability to have orgasms are more separate clinical entities. Although sexual inhibition is often associated with orgasmic difficulties, a proportion of women complain of an absence of erotic sensations (they feel 'dry and tight'). However, once stimulated through clitoris or coitus, they can easily react with the orgasm, even in the presence of poor lubrication.
The psychological reactions to the disorder differ considerably in terms of gender: whereas for men, the erectile

dysfunction is generally a psychological disaster irrespective of sexual orientation, women present more varied reactions, ranging from equally profound anxiety or depression to passive acceptance of the situation. These differences largely reflect cultural influences. In many heterosexual social circles, there is still a widespread belief that women's role in sexuality is to give pleasure to men and to procreate. Some women agree to have sexual intercourse with their husbands in order to save their marriages, engaging in non-sexual fantasies and waiting for their partners to ejaculate quickly. Others, on the other hand, develop intense hostility towards their partner and, for fear of the consequences of rejection, develop avoidance strategies such as illness, fatigue, or they deliberately provoke an argument shortly before.

It is important to note that this disorder does not deprive 'the organs in question', i.e. penis and vagina, of their essential characteristics as one often reads in sexology textbooks, but the two 'persons in question'. This difference in approach is fundamental.

If I begin to think that there is something wrong with *my penis* or *my vagina* – that *they do not work* – I apparently absolve myself. In this case, I separate myself from a part of me that I define as dysfunctional, while *I* would like and continue to long for sexual intercourse with the other. However, by doing so I call myself impotent, as I have no power over a part of me that is beyond my control and acts against my will.

If, on the other hand, we take responsibility for making penetration impossible and accept that, beyond what may be our emotional or cognitive perceptions, we are expressing a refusal of genital contact with the other, we are once again 'potent'.

The difficulty lies in the fact that we are not aware of this rejection. We have alienated ourselves from it and offload the same difficulty onto a part of us, de-sensitising ourselves.

Let us do like Muzio Scevola, who burns his hand on the brazier to punish it for stabbing the wrong person.

Power entails responsibility. That is, the ability to oppose one's partner and to sustain the confrontation.

Here is a first relational datum: erectile or lubricative impotence is always a *de-responsibility with respect to a relational dynamic*. It is a survival strategy that is expressed through "I would like to, but I cannot". This means seeing the phenomenon in all its extension, which is not only the lack or loss of erection or lubrication, but the fact that I first experience and express the desire to have sexual intercourse. I would like to have it, but then specific fears arise and the courage fails. At that point, I remove myself from the boundary with the other, I no longer see my partner clearly because I come into contact with unacceptable parts of myself. In other words, I come into contact with the fear of bringing out my deepest needs and being left alone. *In my survival strategy it is more acceptable to turn out to be inadequate, than 'bad', incapable, or rejecting.* "I don't want to" is not expressible, while "I can't" seems much better. *In dealing with these survival strategies, the exploration of the field that made them effective is crucial*. If it is better for me to be inadequate than to be bad, it means that I have grown up in a field that has supported this experience. In therapy, we often run the risk of supporting fields in which there is a strong demand for adaptation. Being punctual, not skipping sessions, expressing emotions, bringing in one's own experiences, coming into contact with one's own feelings, etc. These are many of the behaviours to which the patient is asked to adjust. When we work with patients who come forward with impotence as a symptom, we have to be aware that every time we support an adaptation, especially if it is implicit, we give them a field in which their solution – their 'disorder' – is effective. Many failures in the treatment of this particular disorder are a consequence of this unawareness on the part of the therapist.

In the case of secondary erectile impotence, it is interesting to note that the first episode reported by the patients is generally related to situations of a request and a 'demand' for sexual performance in which the man experienced impotence not only at the genital level, but also in other relational dynamics. In his relationship with his partner, he felt inadequate, unable to satisfy her/him, not 'enough' for her/him. In his experience, a situation of pressing sexual demands may represent an attack on his value. Questions like "Why don't you want to make love?", "Don't you want me anymore?", "Don't you see me beautiful anymore?" easily trigger a sense of guilt and deprive sex of the spontaneity and freedom that are indispensable for sexual reflexes. Sexual arousal, in both men and women, is a spontaneous reaction to desire and effective stimulation. The expectation and pretence of sexual performance reflect a relationship situation of difficulty that presses to the surface. If the partners do not risk facing it, then they will probably end up avoiding it. From this moment on, the fear of sexual failure will become the immediate cause of impotence.

Even in the female experience, performance anxiety has a powerful effect on the lack of lubrication. In situations of "undemanding" sexuality – in which therapists invite the couple to an exchange of pleasurable sensations by forbidding coitus – the woman, freed from the pressure of needing to be aroused, having an orgasm and satisfying her partner, often comes to experience intense erotic and sensual sensations. The fact that the partner "renounces" the desire for orgasmic satisfaction may be, in the woman's experience, a very

touching proof of how much he/she cares about the sexual pleasure of his/her partner/wife. In this situation, she can regain "responsibility" for her own sexual pleasure, discovering that she will not be rejected or humiliated if she expresses her desires and shows her partner that she has an active personality.
Jaspers (1913) taught us that there is no such thing as dysfunctional behaviour. Every behaviour is functional for something, the difficulty lies in discovering 'what for'.
As with any contact phenomenon, it makes no sense to talk about the refusal of genital intercourse without talking about the field. There are people who can masturbate but become impotent in the relationship. Other people are potent when they have sex with their husband or wife, whom they may not desire, but become impotent in an occasional relationship that excites them greatly, or the other way around. Others who experience potency in the initial phase of intercourse and then lose it while it proceeds. People who are powerful only if they have intercourse under dangerous or embarrassing conditions or with the risk of exposure, while they become impotent if they are quiet in a bedroom. Others experience potency only within sadomasochistic relationships and so on.
So, the first useful question for those who find themselves experiencing powerlessness is: "What is going on between us?", not "What is happening to me?". And immediately afterwards: "What am I trying to communicate to the other person?".
The first question therefore concerns the 'between' (Kimura, 2013). Impotence, even if it is only expressed by one of the members of the couple, is commonly a co-constructed phenomenon and, therefore, it has an individual, a co-constructed and a situational component.
From a therapeutic point of view, in order to support the patient to regain responsibility in the relationship, it may be helpful to invite him/her to identify with the genitals. A large part of the impotence strategy consists, as we have seen, in separating myself from my genitals by attributing the dysfunction – and thus the responsibility for it – to them. Here, then, I can invite the person to imagine becoming his penis or vagina, to describe themselves as if they were their penis or vagina: what characteristics, size, shape, aspect. What qualities, strength, gentleness, softness, what emotions, fear, impetuosity, voracity, shyness. And then I ask him/her to speak, to come up with what he/she would like to say as vagina or penis and to whom he/she would like to say it. Depending on what he/she expresses, I can invite the person, as penis or vagina, to talk to himself/herself sitting in another chair, or to talk to his/her partner, or to one or both parents, or to any other significant person in his/her life, including me, the therapist.
I remember a 28-year-old man who came to our centre for a 'series' of 'dysfunctions of his penis'. He had been to a doctor because he suffered from premature ejaculation. The doctor had prescribed an ointment to be smeared on the glans just before penetration, which had caused the man a bout of impotence, which had since taken the place of premature ejaculation.
The man, whom we will call Sergio from now on (obviously not his name), was very angry with the doctor and he accused him of having caused him more stress by triggering an even more serious disorder that he did not have before.
I had the doubt that perhaps the doctor's intervention, seemingly deleterious, had instead brought out from the ground a phenomenon that was not immediately comprehensible.
We began a progressive exploration of Sergio's relationship with his own penis. Our dialogue brought out embarrassment at first, then shame, and eventually annoyance and rejection with much greater energy.
We talked about masturbation, which for Sergio was always a violent experience often leaving small lacerations on his skin. I was reminded of some words by Perls who claimed that many men, during masturbation, rape their own penis with their hand.
The next time I asked Sergio to bring some clay with him and asked him to model his own genitals with an erect penis. It was a long and difficult operation: the size never seemed right to him, either too small or too big, then it was deformed, ugly anyway.
When I then asked him to place the statuette of his genitals on the seat in front of him and speak to it, contempt and disgust emerged.
Mariano: *"Do you realise you are homophobic?"*.
Sergio: *"What do you mean? I have nothing against gays!"*.
Mariano: *"Homophobia means fear/rejection of one's sex and you are expressing a definite rejection of your sex"*.
For Sergio it was a kind of revelation.
When he was able to identify with his own genitals, he was able to express his own fear/terror of the vagina to which he attributed characteristics of strength, violence and cruelty. It also emerged that while masturbating he identified with the female figure and not the male one.

The therapy went on to bring out the powerful and introjected female figures and the despised and alienated male ones.
Gradually accepting to explore his own male being by recreating the experiences through which he had constructed his manhood, he began to feel the penis as himself and not as an object of use.
This process of identification with the genitals is fundamental to reopening one's inter-body awareness, feeling one's responsibility and thus one's power. It is clear that I speak of responsibility and not of 'guilt'.
The level of inter-corporeality is what therapeutic work slowly brings to the surface.
Beginning to accept that I do not possess a penis or a vagina, but that I 'am' also a penis and a vagina and express myself through actions, is a fundamental step to recover the sense of my rootedness in the relational situation: that is, my personal strength.
People often do not understand how it is possible for them to feel aroused in the whole body except in the genitals. Or to be genitally aroused in a relationship situation in which sex is not at stake. It happens especially to men for aesthetic reasons. It is totally inappropriate if a man has an erection while consoling a crying friend, or playing with a child, or dancing, or engaging in exciting activities that are, however, not sexual. Of course, this also applies to women, but since the phenomenon of moistening is less obvious, women are less often forced to alienate themselves from their genitals.
Because that is what we ask ourselves, to function in watertight compartments. To have sensations running through our whole body, but not through our genitals.
We are trained to alienate ourselves from our genitals, to feel them as a foreign part, practically endowed with a life of their own, but having little to do with us. Why is it so strange that this phenomenon can occur automatically when there is perhaps an emotion, a feeling or a thought for which we do not want to take responsibility?
The term 'penetration', when used to describe sexual intercourse, has specific meanings in terms of the quality of contact. It refers to the action of the penis entering deeply, making the vagina a passive 'inside', and the penis an active intruder.
This is an absolutely man-centred vision that has nothing to do with phenomenology. From a phenomenological point of view, there are times when penetration occurs, times when 'vagination' occurs and, most of the time, they both occur at the same time. It is interesting, however, that the term vagination does not exist: it is a neologism that should enter the mainstream vocabulary and that would be of valuable help in overcoming impotence. In the common and vulgar language, it is said that the woman 'gives it'. Yet it is the vagina that physically 'takes'.
The lack of lubrication in the woman often expresses precisely the refusal to be penetrated. The refusal to this intrusive action of the man and of being passive. This is even more evident in vaginismus, in which – even with the use of lubricants – the pain is intense and totally prevents penetration.
We frequently deal with these issues with straight women who find it very difficult to conceive of themselves as active, in the sense that it is they who 'vaginate' and possess the male. They manage to conceive of themselves as active in various ways and at various times during intercourse, yet the moment of penetration is always a moment of passivity in which at best they can accept and welcome the man's penis, but never 'vaginate' it and actively take it. Let us be clear, even being passive is fine and can be a source of pleasure, but if it is experienced as inescapable, as the only possibility, as evidence of the reality of the woman who is physiologically made to be possessed by the man, then it can arouse fear and rejection in many women.
Even in men, on the other hand, the act of penetration can be a source of fear. There are men who feel that it is not they who penetrate the woman, but she who 'vaginates' them. This perception, instead of relaxing them, makes them feel inadequate, in danger. The famous fantasy of the 'toothed pussy' that could castrate the man reflects this kind of perception. It is experienced not as a phenomenological fact, but as something 'wrong', 'not right': the man should not feel this way or the woman should not behave this way. Many men report phenomena of impotence experienced with women who are unexpectedly very active and resourceful.
Recovering one's sexual aggression, that is, recognising the right to confront our partner with our emotions, fears, rejections, desires, while we are having sex is a fundamental aspect of sexuality. Verbal sharing is an integral part of sexual intercourse. Being able to ground oneself in one's genitals during the situations of our life in which genital contact is not required, but rather determination, assertiveness, curiosity, courage; in short, making the genitals an important part of our body during various relational moments and not only when we want to have sex, is a further and fundamental step towards overcoming erectile or lubricating impotence.

3. Premature ejaculation or premature orgasm

Premature ejaculation, together with delayed ejaculation and orgasmic impotence, represent the broadest category of orgasmic disorders. Orgasm is a discontinuous event compared to the continuum of desire, arousal and quiescence.
In women, it is characterised by a series of involuntary contractions of the vagina occurring approximately every 0.8 seconds and numbering from 3 to 12. It lasts between 3 and 15 seconds and is associated with a slight dulling of consciousness, a rise in blood pressure and heart rate. Orgasm is a reflex that is triggered by predominantly vaginal or clitoral stimulation. In men, it is associated with a series of 3-7 ejaculatory jets occurring approximately every 0.8 seconds.
Female premature orgasm is not reported as a 'problem' because it does not necessarily lead to the interruption of sexual intercourse as is often the case with premature ejaculation. Moreover, it is not invasive for the masculinity of the male partner since he is able to make his partner have an orgasm and can therefore feel powerful.
Both phenomena, however, result in a similar experience, that is an orgasmic discharge of low intensity, generally lacking the physical phenomena which are typical of orgasm, including uncontrolled movements of the pelvis and jolts through the whole body. But more importantly, generally lacking the relational characteristics of orgasm, such as the sense of fusion, loss and surrender to the other.
The Freudian theory considers this symptom from the male point of view as evidence of an unresolved oedipal conflict. Premature ejaculation would express sadistic feelings towards women (*primarily* the mother), the intent to defile them, to deprive them of pleasure and, finally, the attempt to keep the conflict repressed, i.e. out of consciousness. According to the transactional point of view, the woman's request to delay ejaculation is perceived as an attempt to dominate it. Therefore, his incontinence unconsciously represents rebellion against the controlling mother.
According to Gestalt' field epistemology (Robine, 1995), every disturbance arises in the here-and-now of contact and it concerns what the individuals, with their history, are co-constructing. Thus, if there is hostility, it may be related to an area of fragility with respect to the childhood history but, in any case, it arises because of something that is happening between the partners. Suffering is first of all 'relational', before being individual.
Let us see how these phenomena differ from impotence.
They are both forms of anxiety, which, however, occurs at different times.
Here we are not faced with a refusal of penetration or vagination, but with an urgency to conclude. In the case of impotence, the experience is rejected as dangerous and the danger is experienced as imminent, present in the now of the situation and therefore avoided. In precocious ejaculation or orgasm, on the other hand, sexual intercourse is sought and the danger seems to be projected into the more or less distant future. Therefore, we must shorten the time as much as possible in order to prevent this future from materialising. The experience of discovering and co-constructing shared pleasure is lost, the increase and discharge of genital sensations is sought in the ground. The growth of sexual pleasure is disconnected from the growth of the couple's contact and intimacy, which takes time: it occurs when the partners can feel and communicate the sensations and emotions felt during sexual activity, express their desires and fantasies.
From the point of view of the contact cycle, the man experiences anxiety at the moment he reaches a high level of arousal. Anxiety can be related to the fear of being passed over and holding such intense feelings, of not being accepted in his expressions, of being judged, and more. It is this anxiety that creates a desensitisation of the genital sensations and the involuntary orgasm. Thus, paradoxically, the cause of premature ejaculation is not excessive sensitivity, as is commonly believed, but, on the contrary, desensitisation. Anxiety, in fact, plays an indirect role in the genesis of precociousness. The point is that the person loses contact with the genitals and does not perceive many of the sensations that prepare and lead to orgasm. Apart from the rapidity of the ejaculatory reflex, the person is unable to exert voluntary control over the reflex itself (Kaplan, 1974).
Some studies assume that a high level of arousal is the result of an intense imagination, which anticipates reality, precedes it and, to some extent, replaces it (Fenelli and Lorenzini, 2012). Arousal, therefore, is linked more to the imaginative experience than to the concrete one. According to this reading, fantasy and thought replace the contact with the partner, who would remain present only in the ground. Precocious ejaculation, with its rapid acceleration of arousal, could be the relational solution for experiencing sexuality as a purely genital discharge, avoiding the experience of sharing and intimacy with the real person. It is a solution that may generate unwanted consequences, such as frustration, loneliness, anger when the partner desires a more prolonged or intimate sexuality. From this point of view, anxiety arises as a prediction of the costs I will have to pay for my isolation in a fantasy reality. It is the realisation of failure that is constructed as a dangerous

event.
As it is the case with erectile and lubricatory impotence, the experience is perceived differently by men and women.
For men, performance anxiety is normally in the foreground. The fear of not being able to control ejaculation – with the consequent experience of inadequacy – and of leaving the partner unsatisfied is so strong that his own dissatisfaction takes second place.
The woman, on the other hand, is more in touch with the frustration of not being able to cope, to contain the excitement and thus preventing herself from having a stronger and more satisfying orgasmic experience.
The man experiences it more as a lack towards his partner, the woman as a lack towards herself and only later towards her partner.
This inability to contain, to withstand the growth of arousal is common to both experiences. In both men and women, we find the inability to be in touch with the genital sensations by containing them. This is a phenomenon of which the person is aware, although the consequences they draw from it are often misleading. In common feeling, but unfortunately also sometimes on the part of some 'experts', the idea that in order to lengthen time the person should concentrate on 'something else' is still persisting. In this sense, the most varied strategies are applied, such as mentally repeating a poem, or a football formation, or thinking about one's mother or father. These strategies are more masculine than feminine, and are ineffective, unless we are in a context of lack of involvement, such as the set of a porn film or a paid sexual performance in which there is a need to maintain a state of arousal of the genital organs for a long time in a context of lack or conscious refusal to experience sensual and all-encompassing arousal.
In the context of sexual intercourse with a partner with whom there is amorous involvement and generalised arousal, the most effective strategy is just the opposite: a careful concentration on the genitals, combined with breathing contact. Every orgasm, even a very weak one, is still accompanied by an acceleration of breathing, so if we keep our breathing slow and long, especially with prolonged exhalations, the control over our arousal increases and thus also over the triggering of the orgasmic reflex. The contact with our genitals allows us to focus on the sensations that precede ejaculation on the body level: as such it must increase, not decrease, to extend the duration of sexual intercourse.
However, it is here that we enter the nerve centre: do we feel like increasing the duration of sexual intercourse? Do we want to feel the excitement growing? To contain the tension for a long time, maintaining intense and prolonged contact with our partner, until we experience an explosion so intense that we lose ourselves? That we feel our boundaries dissolve? That we lose the sense of ourselves?
These questions bring out the intentionality of the couple's contact, which may be on the side of increasing their intimacy or, on the contrary, of separation.
The early orgasm, for both man and woman, protects us from risking a response.
In working with couples or individuals we sometimes suggest experiencing a particular way of having sex. The 'special' experience consists of going through all foreplay according to their tastes and preferences, but then, before acting out penetration and/or vagination, to stop and look at each other. To penetrate/vaginate the other person slowly and carefully, to stop immediately, to stay like this, to experience the feeling of being inside the other person or of having the other person inside oneself and then to start talking. Take advantage of the effect of genital arousal which makes boundaries more permeable to talk about things that are close to one's heart. To tell about oneself, one's difficulties, fears, desires and rejections, namely to increase intimacy on the level of verbal communication, while at the same time blocking out any exciting fantasies. To allow oneself to say those things that one normally avoids for fear of the other's reaction, for fear of the partner shutting down or stiffening up, running away or mocking us. To feel the protection that such deep intimacy, such extreme closeness, acts on us. All this without losing contact with the genitals, making small movements every now and then to help keep the genitals aroused. One can talk for as long as the couple wishes. Then perhaps they can focus on sexual intercourse again, letting the excitement build up, and then stop again before the excitement builds up too much, that is when we realise that we tend to speed up our breathing. Then they can start talking again about something else that concerns them both, even discordances, outstanding issues, but never losing contact with the other's body and genital arousal, because this makes it more difficult to act out the usual reactive behaviour, the usual defences or aggressions. This intimacy and sexual excitement disrupts the couple's usual communicative and relational style.
The purpose of this experience is not to have a sexual intercourse lasting two or three hours, although this can happen, but to explore intimacy. To put genitality at the service of communication within the relationship. To disrupt crystallised habits. To get away from the idea that sexuality is a special moment, to be experienced when one has time, when one is not too tired, when there is nothing else more important to do, when there are

no hang-ups or worries, etc.
It means relying on the aggression which is maintained and accepted in the ground of sexuality, to prevent it from becoming prematurely fusional. Aggression is necessary in order to carry those contents that normally distance us from each other, differentiate us. In this figure/ground dynamic in which sexuality and aggression alternate as a figure – but always resting on the other polarity maintained in the ground of awareness –, Eros, Iris and Love can come together again in the experience of the couple.
This experience sometimes has a very powerful effect on the people involved. The phenomenon of premature orgasm disappears and the couple feels the need for intimate communication for the first time. Couples who previously reported having good communication with each other discover a new way of meeting.
At other times, the effect is to trigger a strong rejection. But even in this case, the premature orgasm ceases to be a figure and the couple becomes aware of the anxiety and of the rejection of intimacy. People stop sheltering behind the symptom and accept to see it for what it is: a message, a relational communication.
Proposing contact experiences to the couple is in line with the experimental perspective of Gestalt therapy, as long as we as therapists do not fall into a goal-focused vision for the couple to achieve. In cognitive-behavioural therapy, for each disorder, there exists a list of tasks to be prescribed to eliminate it. In Gestalt therapy, on the other hand, the symptom is part of a self-regulation that the couple learns, it is the best possible behaviour through which the individuals already *achieve something*. They then realise that there are unwanted consequences, so that in the end the result is different from what they would like. In the case of premature ejaculation, the fact of quickly ending sexual intercourse is for some reason important for the couple. The clinical work is to go and see what individuals achieve with this solution. It may serve to minimise the communication and conflict that emerges every time they meet. Premature ejaculation becomes the only way they can make love, even if this solution does not bring them closer together. If you take this possibility away from them, they paradoxically risk to impoverish themselves. So, the confrontation with this hypothetical couple is based on the question 'do you want to eliminate the conflict or do you want to get closer to your partner? If the answer is the latter, it will probably be inevitable to move on from the conflict, but at this point we can work on making the conflict a growth experience and not a destructive one. At this point, *and not before*, it can be useful to propose experiences, as they become part of a co-construction in which it is not the therapist who leads the process. Power passes from the patient to the professional and vice versa; psychotherapy, or counselling, can move away from the logic of dominance that is unfortunately present in the helping professions.
By prescribing experiences to increase self-knowledge, pleasure and intimacy as a couple[4], the cognitive-behavioural therapy adopts an educational approach whose risk is to treat patients as ignorant who need to be educated. This approach can be useful when, for example a person (often the woman) does not recognise her/his right to feel pleasure and does not know how to explore her body. If there are no obstacles, an educator is sufficient. But psychotherapy is a different thing, and its specificity is to remove the obstacles that prevent the person from achieving what she/he wants. Treating a couple who have been together for many years as individuals who are inexperienced with themselves and their relationship may mean taking away the value of the efforts or also the rejections they are making and want to be seen.
The following is a fragment of a session with a patient that we will call M., who came to therapy for premature ejaculation. Also at the end of this session, the therapist proposes an experience concerning selfish behaviour. However, it is not used as a 'prescription' and it emerges within a co-constructed process[5].

M.: "I don't understand what you mean by taking responsibility for the rejection. I want to satisfy my wife".
Therapist: "I get it, you want to, but there is at least one part of you that doesn't, your penis comes right away".
M.: "In fact, it is the one that does not want to".
T.: "All right. Then I ask you to divide yourself into two. On one chair there is you and on the other there is your penis. When you are there you explain to your penis what you want and why. When you move to the other chair you become your penis and explain to M. what you want and why. Start with the first chair".
M.: "I want to last a long time, because I want to satisfy my wife. I want to stay inside her as long as it takes for her to come".
T.: "Go to the other side and become your penis".

[4] See footnote 1.
[5] The third phase of occupational therapy includes, among other prescriptions, what Kaplan calls 'permission to be selfish', in which partners are invited to masturbate and, alternatively, receive or give.

M.: "I don't give a damn about her orgasm. I just want to explode. When it's time to enter her, I want to be able to come straight away. What a pain in the ass to go on and on, I want to come and instead I have to hold back because she takes so long, what a pain!"
T.: "Go back to the other chair and tell me what you think about what your penis has said".
M.: "He's actually right. Sometimes I think that I have no desire to waste all that time".
T.: "Then it's not your penis talking. It is always you. We can say that there is an M. who wants to last a long time and satisfy his wife and an M. who wants to think only of himself and come at once".
M.: "Yes, it is like that. There is a selfish me, but I don't like it: it's not right to be selfish".
T.: "And what does your wife say?".
M.: "She gets very angry. In fact, she doesn't want to make love to me anymore: she says that until I have solved my problem and am able to last enough for her to have an orgasm, there is no point in making love".
T.: "So your wife is selfish, too. She is only concerned with her own pleasure as well as you are".
M.: "Well... yes... it is so...".
T.: "So the problem is not premature ejaculation, but egoism. Above all, you two want to be selfish at the same time".
M.: "What do you mean?".
T.: "Well, you could be selfish in turn. First one of you devotes him or herself to the other, turns him/her on and makes him/her come, using whatever means you can think of, and then you switch. It doesn't have to be penetration. Enjoy making the other come... and the other enjoys his/her own selfishness".
M.: "It could be fun. It feels like a game. The few times we try to make love it feels more like work".
T.: "And the selfish M. has no desire to work even when he is lying in bed".
M.: "No, I don't feel like it either".

The process of re-appropriation of the alienated part is very important. M. went from an initial situation in which he experienced premature ejaculation caused by his penis, namely by another from whom he alienated himself, to a situation in which he even corrects the therapist by stating that he is the one who has no desire to make love if it becomes a chore. At this point, it will be possible for M. to realise that he does not need to alienate himself from his selfish 'part' in the progression of therapy, but to accept that there may be times when he feels like being selfish and times when he feels like taking care of the other. It also emerged that selfishness is in the field and that the couple probably needs to confront it, accept it and understand it in its relational value. Egoism was experienced individually as introject. The moment the statement: "It is not right to be selfish" has been redefined as a game possibility (everyone can enjoy being selfish in turn) the partners can regain their spontaneity on the border.

4. Orgasmic impotence and delayed ejaculation

Orgasmic impotence is apparently more frequent in women, because men generally assume that ejaculation and orgasm are the same thing. There are men in whom orgasmic impotence manifests itself in the absence of ejaculation but others present ejaculation without the characteristics of orgasm. Some women, on the other hand, present a very rapid arousal followed by an abrupt drop.
Orgasm is a discharge, stronger or weaker, of the accumulation of tension caused by intense and prolonged sexual arousal. As already stated, it relationally involves a dissolution of boundaries and an experience of fusion with the other. For the individual it is an important experience for the psychophysical balance. Wilhelm Reich was the first to expound on the importance of the orgasm for the health of the individual and medicine has confirmed many of his insights. However, there is no reason to say that the orgasm experienced through masturbation is not equally effective in this respect. Orgasmic impotence very often occurs in genital intercourse with another person and not during masturbation.
From a social point of view orgasm is a paradoxically structuring experience. It is the experience of losing our individuality, of no longer perceiving a separate me from my surroundings. The French call orgasm 'the little death' and the Tibetans call death 'the great orgasm'. Osho (1970), like other Indian mystics, argued that orgasm is the only experience of enlightenment ordinarily available to the human being; namely, an experience of that sudden but permanent state of awareness in which I perceive myself and the world around me no longer as separate and different but formed by a single substance and consciousness. A similar experience to Neo's, the protagonist of 'The Matrix', when he suddenly sees himself and the whole world around him composed of the bits of the programme.

We have called it paradoxically structuring, because *if we can have the experience of losing ourselves, of not needing clear-cut boundaries with our surroundings, it means that we do not need to defend ourselves, that our surroundings are safe and welcoming, that I belong to the world and the world belongs to me*.
Here we already have a first suggestion of orgasmic impotence. If I perceive the world or my partner to be dangerous, and this can happen for various reasons, I would be reckless to let my boundaries disappear and put myself at the mercy of my surroundings. Without boundaries the other can enter me as and when he/she wants and I have no chance of preventing him/her from doing so.
Therefore, if we – also in this case – get out of the perspective of "I don't know what to do about it. I just can't do it" but take responsibility for the event – even if we don't understand the causes – we have to affirm that orgasmic impotence expresses the refusal to surrender oneself to the other, to relinquish control and give up one's boundaries, to accept a little death and a little rebirth together with the other. In other words, *the environment is not safe enough and/or we do not feel strong enough to be totally vulnerable*.
Orgasmic impotence is a close relative of premature orgasm. In fact, both have the effect of preventing the experience of boundary dissolution. The first succeeds by not allowing arousal and tension to rise to the point of no return. The second, through a small discharge, prevents arousal and tension from reaching high levels and thus boundaries from becoming too permeable.
A frequent mistake people suffering from orgasmic impotence make is that they seek and want orgasm. They strive to accelerate the event by trying to 'feel' as much as possible. They are very attentive and this attention ends up preventing the letting go of the imagination; the conscious control over the concrete bodily experience prevents the momentary loss of consciousness that accompanies the orgasmic experience. It is a form of egotism[6] in which boundaries are rigid and do not allow exchange. Men with this problem often seek pleasure as if it were a chore, an imperative and not a desire. Orgasm should neither be wanted nor sought after, because it ends the experience of intense sexual exchange. Orgasm should be avoided and delayed as much as possible. Orgasm is really like a little death: it cannot be avoided but one does not seek it out. The Tao of love, echoing ancient Chinese wisdom, states that a man remains strong and healthy by ejaculating once out of seven sexual intercourses (Chang, 1982). If we do not take this literally as a prescription, it shows us how much more important intimacy and deep sexual contact with each other are than ejaculatory discharge.
Working with orgasmic impotence therefore always takes place on several levels. One level is that of the individual and of the field to bring out the fears and dangers that make the environment so unsafe for the person. Another level is that of supporting for the contact experience in the couple to allow the person and the couple to discover, in the here and now of their relationship, what dangers are present and how much they are avoiding contact with the current dangers, perhaps projecting past ones onto the present situation.
As with early orgasm, the experience of slowing down the genital movements to the point of almost stopping them, in order to talk, to face suspended issues or fears, to foster the growth of intimacy and thus experience a safer field is often of great help. Moreover, this way of experiencing sex is already a satisfying experience, so much so that couples sometimes decide not to reach orgasm and that tends to dampen the anxiety of 'not being able to get there'.

5. Vaginismus and penile disease

In Chapter 16, 'Perineum and Soul', vaginismus-related suffering is developed extensively as a particular area of Flavia Mahnic's work.
The male counterpart of vaginismus is usually referred to by the generic term penile disease which also includes phenomena such as priapism and curved penis. If we speak only of the phenomenon of painful erection, we find a very similar dynamic in both men and women, namely a contraction of the perineum and the muscles of the vagina in women and of the corpora cavernosa of the penis in men which oppose dilation in the former and erection in the latter. Whereas for vaginismus the psychological component is now almost universally accepted, erectile pain in men is almost always traced back to organic causes and men more rarely come to therapy for

[6] With the term *egotism* in Gestalt we indicate that particular interruption in the contact process due to an increase in anxiety immediately before or immediately after the experience of full contact. Full contact is a transformative experience that changes us, slightly or in a major way. If the experience of being changed and affected by the encounter with the other person frightens us, we can detach ourselves from feeling the experience by using the egoic function of logical thought. For example, I can feel tears well up in my eyes and my heart swell with emotion and if these feelings frighten me I can come out with: "It's silly to get excited like that". Or, during a gripping experience, I can come out with a funny joke that prevents me from fully live the experience. Boundaries stiffen again at the moment when they are about to dissolve.

this reason.
We have already emphasised the experience of the genitals as detached from the person who often feels them as having a will of their own; this alienation becomes extreme in vaginismus and erectile pain. The person is totally unaware of opposing something he/she is saying he/she wants to do. In the various types of impotence and early orgasms/ejaculations we often witness a kind of manipulation of the genital experience, whereas in this suffering the opposition is sharp and violent: a violence, however, which is totally alienated.
Women frequently show feelings of anger, either at themselves when vaginismus is such that penetration is completely impeded, or at their partner when the contraction makes intercourse painful. In this case the anger is towards the partner who insists on having intercourse anyway. In men the dynamic is similar. The anger is usually directed towards themselves but often also towards their partner who is accused of not being gentle enough.
Identifying with one's own anger is often a crucial stage in working with vaginismus and erectile pain, as will become clear in the examples Flavia will bring in Chapter 16.
Anger is frequently brought reactively into the sessions and the therapist is easily accused of not understanding the person's experience. It is particularly difficult to encourage the person to take responsibility for the phenomenon because the alienation is total. *The therapist must be prepared to have very 'hot' moments of confrontation*. It is important to build a climate of strong intimacy and security before the person accepts to look at his/her suffering as an ally and not as an enemy and the same applies to the relationship with the professionist.
It is impossible for the person to feel his or her own strength in the release. Most of us, due to our Eurocentrism, share a cultural[7] introjection that strength lies in contraction, hardness, violence. Few women would claim to experience the strength of their vagina in releasing its muscles and 'grabbing' the penis or fingers or an object. The majority of women report at most the experience of opening to receive. Yet we relax our jaw muscles to open our mouth and bite, grasp, suck food. Only toddlers and severely disabled people are fed.
In the chapters on aggression, we have seen how the transition from oral to dental aggression is characterised by a shift from a manipulative activity towards the environment precisely in order to obtain feeding (e.g. crying), to a directly destructive and transformative activity in order to make the environment suitable for us. As always, it is a question of bringing out the intentionality expressed by the phenomenon.
In vaginismus, it is useful to explore whether the woman is refusing to be 'vaginised' and has not yet developed the ability to 'vaginate'[8] or whether both forms of aggression are being rejected and the result is a tendency towards annihilation, i.e. anal aggression (see section 4 of chapter 13).
In erectile pain, a similar phenomenon emerges. The intentionality that emerges, i.e. the attribution of meaning developed in and with the environment, is that the environment is neither welcoming nor penetrable. This feeling, however, is not acceptable, so we develop a substitute intentionality: the environment is not dangerous, I am the one who feels pain, I am in pain, I am not afraid. "I want to, but I am in pain" turns into "I cannot". As always when speaking of intentionality it is not meant that I consciously create the pain but that it occurs in the encounter between me and the other.
Even though the pain is in the erection and the genital contact with the other may not yet be there or even the other may not yet be present, it is desire, fantasy – and therefore the other – which causes the erection.
Perls argued that male masturbation often results in hand rape of the penis. In vaginismus the woman contracts the muscles of the vagina as if to protect herself from rape which she does not recognise as such; if the intercourse takes place anyway, the consequences are similar. With man, one never thinks of the fear of being raped, except in the anus, because rape is towards a cavity, towards one who does not want to receive it. But the meaning of the word rape is not related to penetration. Rape means offence, constriction, beating, violence. As we have written about delinquency, rape has nothing to do with sexuality. It is not the penis, it is the hands that rape, that beat, block, coerce. In both vaginismus and erectile pain the person experiences genital contact with the other with the fear of pain, of constriction, of lack of care. I do not feel afraid of the other, in fact the

[7] The term introject, in Gestalt therapy, refers to a particular interruption of the contact process consisting of treating something that we have been told, taught, con- won, obliged to, as if we had experienced it and therefore had a certainty of it derived from a direct and sensory knowledge. An example: a child approaches a power socket; his father tells him not to stick his fingers in the socket because he would get a painful shock. Subjugated by his father's authority, the child no longer goes near the socket. Some time later the same child is with a peer who approaches a socket. The first child tells him not to touch it because it hurts. The second child does not listen to him and slips his fingers into the socket getting a shock. For the first child the danger of the electric current is an introject, for the second child it is an experience.
[8] In-vaginate is the movement in which the woman takes in the penis (or other objects), relaxes her musculature and allows herself to be penetrated, while vaginate is the movement in which the woman activates her musculature and actively takes in the penis or other objects.

other has nothing to do with it; I am the one who feels pain, I am responsible.
It is a process similar to shame, in which those who experience it attribute the responsibility for what they feel to themselves: “It’s not you! It’s me who is ashamed”. I no longer recognise that it is the other’s action that generates the shame in me, I only feel ashamed (Robine, 1995).
Together with the identification with anger, the recognition of shame as a field and not as an intrapsychic phenomenon is another fundamental step in working with vaginismus and erectile pain. And we therapists are part of the problem. We are the rapist environment, we make the patient feel ashamed, we make the patient feel pain, we are the other. If we do not accept this responsibility, if we only want to be seen as helping, if we are compulsively loving, the person will not be able to value fear, anger and shame, to understand what role they play in his/her life and what they are protecting him/her from.

6. Homophobia and possession

We will now outline a particular interpretation of homophobia and possession, precisely in terms of sexual disorders and therefore not as social phenomena, as they are normally considered.
Let’s start with homophobia. The fear of one’s own sex. When we talk about homophobia, we normally think of the discrimination or the annoyance that some people feel towards homosexuals. In reality, the phenomenon is much broader and affects most of us: it is in the heterosexual couple that it reveals itself. Part of the phenomenon of jealousy is a manifestation of homophobia. This statement may seem excessive. But let us observe some very common experiences in which I believe many of us can identify. I quote here the words of some patients.
S., a 35-year-old woman with a university degree, a high level of awareness and fulfilment in both her work and love life, came to therapy with her husband who confessed to an extramarital affair: “Do you understand that it makes me sick! The thought that you shoved it inside her and then shoved it inside me makes me sick!”.
P., a man in his 40s, himself with a very good cultural and emotional level: “I have never been jealous. My partner has always been free to do anything, but since I found out that she slept with another man... I can no longer touch her... the idea of another man hugging her... touching her... coming inside her... disgusts me to no end”.
L., 30-year-old woman: “I can’t stand him! When he comes up to kiss me... I imagine his tongue was in her mouth... I feel like he can take her saliva into my mouth, it makes me sick”.
G., a 45-year-old man: ever since his wife confessed to him that she was having a lover is obsessed with images that destroy him. “She told me that she gave him a blowjob... but do you realise... I have continuous images of her with his sperm in her mouth, how disgusting!”.
And let us conclude with a scene from a very funny film from a few years ago in which a mafia boss goes to psychotherapy because he is suffering from panic attacks and during a session in which the subject is his sex life, to the analyst who asks him why he allows himself to make requests for sexual practices that are gratifying for him with his lover, while he absolutely avoids it with his wife, the boss replies with a disgusted expression: “Hey, that’s the mouth she kisses my kids goodnight with!”.
There is a common element in these experiences I have found in many accounts of men and women: the disgust at the contact of the partner with the sexual organs or saliva or semen of the other. This particular experience of disgust has never been reported to me by homosexual couples who also expressed strong jealousy towards their partner.
Now, the question is: what is gross about my partner putting his penis in another woman’s vagina and then putting it in mine? Or that my partner has had another man’s penis in her mouth and then kissed me? It’s just that in this way it’s as if I come into physical contact with the other’s genitals and that makes me sick. It disgusts me to imagine this contact and that is homophobia, disgust for my own sex.
Now, this might not be so important if we think of one’s sex as belonging to a gender but it is different if we speak of one’s sex as part of myself. It is a part of me that I consider dirty and disgusting and I do not realise it until I am confluent with it: it is part of me but it becomes immediately apparent when it becomes other than me.
When I am confluent with a feeling or an emotion, I do not perceive it. So, I do not perceive that I feel disgust for my own sex but only for that of somebody similar to me who, however breaks this confluence by being another. This unconscious disgust, however, is present and it may feed a sense of contempt towards my partner to whom I ask to have an intimate contact, precisely with this part of me for which I feel disgust.
The Groucho Marx paradox returns: “I don't care to belong to a club that accepts people like me as members.”.

“I would never appreciate a woman who appreciated my cock”, or “I would never appreciate a man who appreciated my pussy”. All this is obviously not conscious, but also the contempt within a couple that exists between men and women is not conscious, but inevitably emerges when there are major conflicts.
By this I do not mean that therefore we should be happy if our partner has sex with another. We may not want it, we may get angry, but disgust is something else. Disgust is, probably, homophobia. I remember a work with a patient. During therapy it often emerged that he felt contempt for women after he had had sex with them. He did not seem to report any difficulties with his own sex, although he did not like to masturbate. One day I had him bring in some clay and mould his own penis, paying attention to all the details. Then I had him lay it on the chair in front of him and I asked him to comment on that penis. When I asked him to take it back in his hand, he felt a sudden sense of discomfort and when I asked him to identify himself with his penis, feelings of inadequacy, discomfort and shame emerged. When I then invited him to look at me and tell me if these experiences were present between us, he stared at me for a long time and his eyes and mine filled with tears. We both felt ashamed and talked about it at length, about his and mine. He said it was the first time he had experienced such a strong sense of intimacy with a man and he had never thought it was possible. It was one of the turning points of our work.
We come to another component of jealousy: possession. Feeling that she is mine, that he is mine, is an important component of the relationship. In the marriage rite, it is explicitly stated that people now belong to each other. In particular the other’s body becomes my property and, even more specifically, the genitals.
This possession is set off in many ways. There is no betrayal without contact with the genitals. The kiss may be accepted, if it has been occasional but the genitals are not. A lot can be tolerated and accepted but not that *my* woman or *my* man makes love to another. This can put an end to an important relationship, to a marriage with children, to important feelings or experiences. I could say that I love my partner more than my life, that I could do anything for her/him... but if she/he has sex with another man/woman I am ready to leave her, to separate from her/him forever.
Possession is also present within same-sex couples.
In relational terms, possession guarantees to me that thing is mine as long as I want it. This is important: it will not be mine forever but only as long as I want it. In addition to making the other person an object, I make him/her my property. This is apparently reassuring, it calms my fear of abandonment, my insecurity of being less worthy than others. Actually, this is a very anxiety-inducing solution. If she/he is with me because she/he is mine, because she/he belongs to me, then she/he can be stolen from me and all the other men (or women) become potential thieves to be watched with suspicion. I do not realise that the only thing that can reassure me is to accept that she/he is in love with me for who I am, for my peculiarity. That doesn’t mean that she/he can never find someone else she/he can fall in love with but it’s not determined by having sex.
Becoming the owner of my partner’s genitals is specifically an ancient sign of possession that had its highest expression in the imposition of the chastity belt. Now that we have almost reached equal rights between men and women (at least in some countries), the chastity belt is also imposed on men.
But why is it so important to possess each other’s genitals? Originally, when the earth was under-populated, it was probably the need to possess such an important means of production as the woman’s vagina. In fact, for a long time this possession has only been exercised with regard to the female sex, since the male sex is less important and replaceable as far as reproduction is concerned.
What makes the possession of the other’s sex still so important today, even among culturally and emotionally evolved people?
Both genitals help create life. They are the source of the greatest pleasure a human being can experience and they have this incredible power of being the bearers of the substances necessary to create life. All the major religions on the planet have, in various ways, emphasised the importance of controlling the genitals. The three major monotheistic religions have considered genital control as a fundamental aspect in the elevation of the spirit. Giving one’s genitals to another human being has become the symbol of giving him/her the most important part of oneself. It has become the material way of giving one’s immaterial soul. Genitals are recognised as the most intimate part of our body, so giving the exclusive possession of my genitals to another takes on the sense of giving him/her possession of my deepest intimacy.
This concept was widely contested in the 1960s and 1970s. Free love had become the banner of the cultural revolution of those times. The rejection of property as a means of discrimination between men was considered central to the thinking of the time, hence also the rejection of ownership of each other’s intimacy. The negative aspect of this thinking was the disconnection of sex from love. A re-proposition of the mind/body division in which it was acceptable to have sex without any emotional involvement: some purely pleasurable gymnastics. In order to reject the concept of possession, the intimacy of which the genitals are bearers was also rejected.

Recognising the importance of the genitals in the equal exchange between human beings by acknowledging the intimacy they represent is important within couples. Refusing to identify with possession is not the same as denying the importance of genital contact. It rather means recognising that there is a need for intimacy that is not satisfied within the couple and that the person seeks elsewhere. Without the anger or the offence that comes from feeling that the other has betrayed a contract of ownership, the fear of losing the other emerges and also the recognition that intimacy between us is not enough: offence and anger protect us from feeling vulnerable in the face of these fears.
Eliminating betrayal and possession allows the event – having sex with someone outside the couple – to be brought back to its relational value, namely that something is missing in the couple's intimacy. It is no longer 'the other to be guiltyt' but the couple that does not satisfy the needs for intimacy that the field in which we are immersed stimulates. This does not automatically mean that there is something wrong and that the couples should be able to satisfy all the intimacy needs of the individuals. However, it is important to value the event in order to understand whether the couple is aware of what they are not able to satisfy in the individuals, so that even the acceptance that 'there is something missing at the moment' can become a support for the growth and evolution of the couple. We should not give up jealousy but the 'right' to be angry at the other's betrayal. This right lets aggression express itself by denying love in an antithetical form. There is no sexual aggression, only aggression. The extreme example is Othello who goes so far as to destroy the person he loves. It is possession to be extreme in Othello's jealousy and that prevents a confrontation, no matter how heated, which would at least be sustained by a ground of love.

The following chapter is the contribution of Flavia Mahnic, a perineal rehabilitation therapist. It is an important contribution because, starting from her personal experience as a woman and from an organicist and physiotherapeutic background, she takes us on a journey through the perineum and genitals, linking the lived body with the anatomical one with clarity, simplicity and scientific rigour. As the chapter title says: Perineum and Soul; it shines an original light to understand, study and treat sexual dysfunctions.