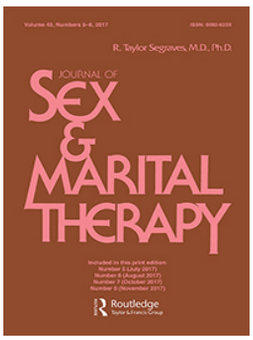

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Body Awareness and Bodily Dissociation Among Those With and Without Sexual Difficulties: Differentiation Using the Scale of Body Connection

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The goal of this study was to explore potential body awareness and bodily dissociation differences between men and women with and without sexual difficulties, using the Scale of Body Connection in a sample of 909 participants. In women, bodily dissociation scores were significantly higher across all reported sexual difficulties, except in sexual pain. Women with lack of sexual interest and sexual arousal had significantly lower body awareness when compared to women without these difficulties. These findings suggest the importance of targeting body awareness and bodily dissociation in the treatment of women's sexual difficulties.

INTRODUCTION

The Scale of Body Connection (SBC) was developed to examine body awareness and bodily dissociation, specifically awareness of and sense of association to inner body sensations (Price & Thompson, 2007). The SBC has been used in multiple therapeutic intervention studies, primarily research involving mind-body (e.g., body-oriented therapy, yoga, mindfulness) approaches that teach new skills involving increased awareness of and association to the body for managing distressing health symptoms. These studies have demonstrated significant reductions in body awareness and/or dissociation using the SBC among individuals in treatment for pain (van der Maas et al., 2015), substance use disorder (Price, Wells, Donovan, & Rue, 2012), and in recovery from sexual trauma (Price, 2007).

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In the sexology field, connection to the body is considered critical for the treatment of sexual problems and dysfunctions (Brotto, Basson, Carlson, & Zhu, 2013; Brotto, Chivers, Millman, & Albert, 2016; Brotto & Heiman, 2007; Carvalheira & Vilarinho, 2013; Maltz, 2012). Research has demonstrated that sexual dysfunctions are related to cognitive distractions and lack of attention to sexual stimuli (Barlow, 1986; Cuntim & Nobre, 2011; Dove & Wiederman, 2000; Masters & Johnson, 1970; Nobre & Pinto-Gouveia, 2008; Wiederman, 2001; Wiegel, Scepkowski, & Barlow, 2007). Importantly, cognitive distraction involves disconnection, or avoidance of body sensations, as a result of nonerotic cognitions— for example, thoughts related to sexually transmitted infections/pregnancy, morality, guilt or regret (Purdon & Holdaway, 2006), thoughts about body image concerns (Dove & Wiederman, 2000; Meana & Nunnink, 2006), or sexual performance (Barlow, 1986). Moreover, some studies showed that cognitive distraction during sexual activity reported by women is based on concerns about body appearance, whereas men reported cognitive distraction based on performance concerns (Carvalheira, Godinho & Costa, 2017; Faith & Schare, 1993; Meana & Nunnink, 2006; Nelson & Purdon, 2011; Purdon & Holdaway, 2006; Purdon & Watson, 2011).

Notably, sexual problems are prevalent among men and women who have a history of physical or sexual trauma (Halvorsen & Metz, 1992; Postma, Bicanic, van der Vaart, & Laan, 2013; Tekin et al., 2016). Posttraumatic stress disorder (PTSD) is linked to sexual dysfunction (Yehuda, Lehrner, & Rosenbaum, 2015) and has been shown to predict sexual problems in women (Letourneau, Resnick, Kilpatrick, Saunders, & Best, 1996). A common coping mechanism for trauma apparent in clinical care is dissociation from the body (Herman, 1997; Maltz, 2012), and this mechanism may underlie the cognitive distraction among this population who report sexual difficulties. Interventions that promote the focus on bodily sexual stimuli and physical sensations during sexual activity are welcome in sex therapy. Increasing awareness of and sense of connection to the body are considered important for the treatment of sexual problems and dysfunctions (Brotto et al., 2013; Brotto et al., 2016). Mind-body interventions involving mindfulness skills show positive results in the treatment of sexual dysfunctions, namely in terms of higher levels of sexual satisfaction (Mayland, 2005), awareness of existing genital arousal, and increase in genital and subjective sexual arousal (Brotto et al., 2013; Brotto, Basson, & Luria, 2008; Brotto & Heiman, 2007; Brotto, Seal, & Rellini, 2012; Carvalheira & Vilarinho, 2013), and genital-subjective sexual arousal concordance (Brotto et al., 2016). However, the mechanisms by which these interventions lead to these improvements in women with sexual dysfunction are not entirely clear (Brotto et al., 2016).

Given this growing literature showing positive outcomes for sexual problems in response to mindfulness-based interventions, it is important to begin to explore possible mechanisms underlying the effectiveness of these approaches. Mindfulness practice is an ancient tradition in Eastern philosophy that is increasingly making its way into Western approaches to health care. Jon Kabat-Zinn, the foremost pioneer in the therapeutic application of mindfulness in Western culture, defines mindfulness as the awareness that emerges through paying attention on purpose, in the present moment, nonjudgmentally to the unfolding of experience, moment to moment (Kabat-Zinn, 2003). Since being in connection to the body and increasing body awareness are major components of mindfulness-based interventions for sexual dysfunction, research is needed on the relationship between these factors and sexual response. The goal of the present study is therefore to explore potential body awareness and bodily dissociation differences, using the SBC, between men and women with and without sexual difficulties.

METHOD

Participants

The sample comprised 909 individuals, 464 men (51.0%) and 445 women (49.0%). Ages ranged from 18 to 72 years old ($M = 34.08$, $SD = 11.74$), with men ($M = 37.54$, $SD = 12.34$) being significantly older than women ($M = 30.47$, $SD = 9.87$) on average, $t(878.78) = 9.56$, $p = .000$. The majority were heterosexual (88.4%), had a college degree or higher (70.4%), and were in a committed relationship (80.8%). The mean duration of their relationships was 7.84 years ($SD = 8.87$), significantly longer for men ($M = 9.44$, $SD = 9.94$) when compared to women ($M = 6.07$, $SD = 7.12$), $t(737.20) = 5.48$, $p = .000$. All individuals had been sexually active in the last 12 months.

Procedure

An anonymous web survey (SurveyMonkey) was used to gather responses. The questionnaire was hosted on a commercial website dedicated to online surveying. The participants were recruited through passive advertisement on a news portal involving a banner inviting subjects to participate in a study focusing on sexual health. The survey was open for recruitment from September to December 2014. After accessing the first web page that briefly described the study, participants viewed a consent form. Upon agreeing to participate, participants could access the questionnaire. No compensation was provided. All procedures were approved by the Ethics Committee of ISPA University Institute, in Lisbon, Portugal.

The SBC was translated into Portuguese by two independent translators. These versions were separately back-translated by a native English speaker. The final version was pilot tested with a sample of 15 college students and was found comprehensible and equivalent to the English version. There was no disagreement between versions.

Measures

Sociodemographic Variables

These variables were age, residential area by district, educational level, relationship status, and length of the relationship.

Body Awareness and Bodily Dissociation

The Scale of Body Connection (SBC; Price & Thompson, 2007) is a 20-item scale involving two distinct dimensions: body awareness (conscious attention to sensory cues indicating bodily state, for example, tension, nervousness, peacefulness) and bodily dissociation (separation from body, including emotional disconnection, e.g., difficulty attending to emotion). Rated on a 5-point response option from 1 (*not at all*) to 5 (*all the time*), 12 items measure body awareness and 8 items measure bodily dissociation. The original scale demonstrated a Cronbach's alpha of .83 for body awareness and .78 for bodily dissociation (Carvalheira, Price, & Neves, in press).

Distressing Sexual Difficulties

This outcome variable was measured by asking participants how stressful the experience of one or more sexual difficulties was for them. Answers were given according to a 4-point scale ranging from 0 = *not having any sexual difficulty*, 1 = *not distressful*, 2 = *somewhat distressful*, 3 = *quite distressful*, and 4 = *extremely distressful*. Sexual difficulties were measured by the 7-item National Survey of Sexual Attitudes and Lifestyles (NATSAL) measure of sexual function (Mercer et al., 2013). Participants were asked to indicate which of the following sexual difficulties they had experienced for "at least three months in the preceding 12 months": lack of sexual interest, inability to reach orgasm, rapid ejaculation, not finding sex pleasurable, feeling anxious before sex, pain during sexual intercourse, and difficulties with erection.

Sexual Trauma

A dichotomous survey item was used to assess sexual trauma. The item asked, "Since the age of 13, did anyone ever force you to have sex against your will, by using force, threats, or verbal pressure?"

Sexual Activity in the Previous 12 Months

A dichotomous question determined whether a person had been sexually active ("any type of partnered sexual activity") during the last 12 months.

Data Analysis

Data analysis was carried out using SPSS, v.21. When comparing groups, t tests were used to determine if the average scores were significantly different, given a p value of .05. Effect sizes were calculated through Cohen's d. According to Cohen (1988), effect sizes are small if they reach a minimum absolute value of .20, medium if they reach an absolute value of .50, and large if their absolute value exceeds .80. Four multiple regressions were conducted to assess the predictors of Body Awareness and Bodily Dissociation among men ($n = 464$) and women ($n = 445$).

RESULTS

Body Awareness/Dissociation Among Men and Women

Men's and women's scores on each of the two subscales are presented in Table 1. Women had higher scores in both Body Awareness (BA) and Bodily Dissociation (BD) subscales when compared to men. The results of the t tests showed that these differences were significant and, in terms of effect size, the effect was medium in BA ($d = –.56$) and small in BD ($d = –.20$).

TABLE 1
Gender Differences in the Scale of Body Connection ($N = 909$)

Factors	*Mean*	SD	t	p	d
Body Awareness					
Men	3.09	.74	− 8.27*	.000	− .56
Women	3.49	.70			
Body Dissociation					
Men	1.89	.55	− 3.00*	.003	− .20
Women	2.01	.63			

Notes. SD = standard deviation; $t = t$ test; d = Cohen's d.
*Differences significant at $p < .05$.

Body Awareness/Dissociation and Sexual Difficulties in the Total Sample

A total of 405 participants (44.6%), 220 women and 185 men, reported some sort of sexual difficulty for at least three months during the previous year. Moreover, 256 participants (28.2%)—101 men and 155 women—indicated more than one sexual difficulty and 86 participants (9.5%)—42 men and 44 women—found the situation "quite distressful" or "extremely distressful."

The mean BA scores of those with and without distressing sexual difficulties were similar. However, the mean BD score among individuals who reported one or more sexual difficulties were significantly higher, with a small effect size, compared to individuals without sexual difficulties (see Table 2).

Body Awareness/Dissociation and Sexual Difficulties Among Men

Men who reported a lack of sexual interest had significantly lower levels of BA compared with men who reported no sexual difficulties (Table 3). This was the only significant difference among men.

TABLE 2
Comparing Body Awareness and Bodily Dissociation Among Participants With and Without Distressing Sexual Difficulties ($N = 909$)

Factors	*Mean*	SD	t	p	d
Body Awareness					
No sexual difficulties	3.30	.81	.493	.622	—
Sexual difficulties	3.27	.65			
Bodily Dissociation					
No sexual difficulties	1.86	.57	− 4.99*	.000	− .34
Sexual difficulties	2.06	.60			

Notes. SD = standard deviation; $t = t$ test; d = Cohen's d.
*Differences significant at $p < .05$.

TABLE 3
Comparing Body Awareness and Bodily Dissociation Among Men With and Without Distressing Sexual Difficulties ($n = 464$)

	Body Awareness				*Bodily Dissociation*			
Sexual Difficulties	*SC(0)*	*SC(1)*	t	p	*SC(0)*	*SC(1)*	t	p
Lack of sexual interest	3.12	2.91	2.01*	.045	1.88	1.97	− .99	.325
Anxiety during sexual intercourse	3.09	3.08	.16	.872	1.87	2.00	− 1.80	.072
Difficulty to reach orgasm	3.10	3.01	.75	.452	1.88	2.06	− 1.95	.052
Ejaculate too quickly	3.10	3.05	.65	.518	1.89	1.90	− .13	.897
Difficulties in maintaining erection	3.11	3.00	1.20	.234	1.88	1.97	− 1.10	.274

Notes. *SC(0)* = score without the sexual difficulty; *SC(1)* = score with the sexual difficulty; *t* = *t* test.
*Differences significant at $p < .05$.

Body Awareness/Dissociation and Sexual Difficulties Among Women

Women who reported a lack of sexual interest or a lack of sexual arousal had significantly lower levels of BA and significantly higher levels of BD compared to women who did not report these sexual difficulties. Moreover, women who reported anxiety during sexual intercourse and difficulty reaching orgasm had significantly higher levels of bodily dissociation compared to women who did not report these difficulties (Table 4).

Anxiety during sexual intercourse ($d = -0.58$) and lack of arousal during sexual intercourse ($d = -0.64$ in the BD subscale) had medium effect sizes; all other significant differences between women with and without sexual difficulties were small in terms of effect size.

Predictors of Body Awareness/Dissociation Among Women

Age, relationship duration, sexual difficulties, and sexual trauma were included in the model as independent variables (see Table 5). Age was the only significant predictor of body awareness

TABLE 4
Comparing Body Awareness and Bodily Dissociation Among Women With and Without Distressing Sexual Difficulties ($n = 445$)

	Body Awareness				*Bodily Dissociation*			
Sexual Difficulties	*SC(0)*	*SC(1)*	t	p	*SC(0)*	*SC(1)*	t	p
Lack of sexual interest	3.54	3.35	2.62*	.009	1.94	2.19	− 3.99*	.000
Anxiety during sexual intercourse	3.49	3.44	0.45	.650	1.97	2.37	− 4.02*	.000
Pain during sex intercourse	3.51	3.40	1.31	.192	2.00	2.05	− .75	.454
Lack of arousal during sexual intercourse	3.52	3.33	2.23*	.026	1.94	2.33	− 5.07*	.000
Difficulty to reach orgasm	3.53	3.39	1.86	.063	1.96	2.13	− 2.56*	.011

Notes. *SC(0)* = score without the sexual difficulty; *SC(1)* = score with the sexual difficulty; *t* = *t* test.
*Differences significant at $p < .05$.

TABLE 5
Multiple Regression for Body Awareness and Bodily Dissociation Among Women

	Body Awareness		*Bodily Dissociation*	
Variables	*Beta*	t	*Beta*	t
Age	.02	3.12**	− .01	− .14
Relationship duration	− .01	− 1.14	.00	.83
Sexual difficulties	− .12	− 1.69	.21	3.31**
Sexual trauma	.18	1.66	.34	4.11***

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

among women, indicating that as women age they have more body awareness, $F(2, 11) = 8.44$, $p = .002$. For women, sexual difficulties and sexual trauma were also significant predictors of bodily dissociation, $F(2, 84) = 11.38$, $p = .000$. None of these possible factors predicted BA or BD among men.

DISCUSSION

The present study explored the relationship between body connection and sexual response. Specifically, the current study analyzed the potential body awareness and bodily dissociation differences between men and women with and without sexual difficulties. Men and women with and without sexual difficulties reported distinctly different responses on the SBC factors of body awareness and bodily dissociation. While the mean BA scores were similar between individuals with and without sexual difficulties, the mean BD scores were higher among individuals with sexual difficulties compared to those without.

Gender-specific comparisons revealed that the only significant difference between men with and without sexual difficulties was lower body awareness among men who reported a lack of sexual interest. In contrast, women who reported a lack of sexual interest and a lack of sexual arousal had significantly lower BA compared to women without those difficulties. For bodily dissociation, there were no differences between men with or without sexual difficulties. For women, however, BD scores were significantly higher across all reported sexual difficulties with the exception of sexual pain. These findings highlight the relationship between bodily dissociation and sexual difficulties among women. A possible explanation for this gender difference is that women with sexual difficulties experience a higher level of sexual distraction (Carvalheira et al., 2017; Cuntim & Nobre, 2011; Dove & Wiederman, 2000; Nobre & Pinto-Gouveia, 2008; Wiederman, 2001), and this may result in bodily disconnection.

The findings also revealed that sexual difficulties and sexual trauma were significant predictors of bodily dissociation among women but not for men. Sexual difficulties and bodily dissociation are clinically linked and not uncommon among women in recovery from sexual trauma (Herman, 1997; Maltz, 2012). Moreover, the bodily dissociation scale of the SBC has been previously shown to discriminate between individuals with and without sexual and physical trauma (Price & Thompson, 2007). It is thus also possible that the higher level of bodily dissociation among

women with sexual difficulties is related to a higher number of women with a history of sexual trauma compared to men in this study sample.

Finally, among the two scale dimensions, bodily dissociation appears to be more relevant than body awareness for differentiating women with and without sexual difficulties. The BD subscale includes items related to feelings of being separated from the body in a general way and during sexual activity, as well as difficulty expressing emotions. The BD construct involves a sense of separation from the body and bodily sensations and is therefore the antithesis of awareness of and presence in the body. Thus, this separation from the body, this absence, may reveal lower awareness among women than men with sexual difficulties.

Notably, participants in mindfulness intervention studies for the treatment of female sexual dysfunction reported many of the same sexual difficulties as the female participants in this study (cf. Brotto et al., 2008; Brotto et al., 2016; Brotto & Heiman, 2007; Brotto et al., 2012). Given our findings showing that women with, versus without, lack of sexual interest and lack of arousal were found to have significantly lower body awareness and significantly higher body dissociation, it is possible that improving body awareness and bodily dissociation may be important mechanistic targets in mind-body treatment approaches for sexual dysfunction.

There are limitations in this study that must be considered. Our sample may not be representative of the Portuguese population as it was a self-selected sample of Internet users, and those who responded were highly educated. These factors limit the generalization of results. Nonetheless, this study has important clinical implications. The consistently higher bodily dissociation scores across four of the five types of sexual difficulties among women indicate the importance of targeting body connection in interventions for women with sexual difficulties. Sex therapy to treat a lack of sexual interest, lack of arousal, difficulty to reach orgasm, and anxiety during sexual intercourse should include interventions to decrease bodily dissociation and to improve body awareness. Improving body connection may help women to be aware of physical sexual stimuli and consequently improve sexual arousal and the overall sexual response. These results also suggest the use of the SBC to examine potential mechanisms of mind-body interventions for the treatment of women's sexual difficulties. In conclusion, our findings shed light on the relationship between body connection and sexual response and elucidate possible mechanisms underlying the effectiveness of mindfulness interventions for female sexual dysfunction.

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