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How to cite:

Barker, Meg (2014). How social is your mindfulness? Towards a mindful sex and relationship therapy. In: Bazzano, Manu ed. *After Mindfulness: New Perspectives on Psychology and Meditation*. Houndmills: Palgrave Macmillan, pp. 81–100.

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Version: Accepted Manuscript

Link(s) to article on publisher's website:

<http://www.palgrave.com/page/detail/?K=9781137370396>

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How social is your mindfulness?

Towards a mindful sex and relationship therapy

Meg Barker

Introduction

The proliferation and popularity of mindfulness therapies in recent years has enabled many people to access Buddhist theories and practices which are helpful in addressing distress. However, most of the therapies which have been developed so far seem to adopt the dualistic modern western way of understanding experience rather than taking seriously the non-dualistic approach within which Buddhist understandings are embedded. In this paper I argue that a biopsychosocial perspective is more in keeping with the theoretical foundations of mindfulness, whilst also being in line with more recent western theories. Such a perspective requires giving serious attention to the social context in which we struggle which has been neglected by the internal focus of much psychotherapy. Specifically we need to engage with the self-monitoring culture of acquisition and avoidance which currently pervades western society. I refer to such an approach as 'social mindfulness' to distinguish it from those mindful approaches which engage less explicitly with the social.

This paper illustrates these points with the example of sex and relationship therapies. So far, the focus of mindfulness in these areas has been on applying techniques to complement conventional therapies which, broadly speaking, aim at enabling couples to have conventional sex and to stay together in romantic relationships (Barker, 2013c). If sex and relationship therapies are to be mindful then they need to go beyond this and to critically examine the sociocultural understandings of sex and relationships that people draw upon. In particular, they need to address the approach/avoidance patterns which are encouraged, for example, by mainstream media and many psychiatric, psychological and psychotherapeutic understandings of sex and relationships. We need to ask what kinds of sex and relationships people are trying to have and why, rather than accepting these as taken-for-granted. Long-term, a more appropriate aim for mindful sex and relationship therapy (MSRT) (in terms of both individual suffering and the wider world) would be to help people to 'swim against the stream' (Batchelor, 2010, p.125) of problematic social norms and

cultural assumptions rather than continuing to work towards enabling them to fit these.

I write, here, as somebody who has engaged with mindfulness in three ways. First, I have been reading western Buddhist authors such as Stephen Batchelor (1997, 2010), Martine Batchelor (2001), and Pema Chödrön (1994; 2001) for the past couple of decades and trying to apply their ideas and practices to my own daily life. Secondly, I have engaged with Buddhist ideas and practices academically, considering what they have to offer methodologically and theoretically in terms of the ways in which we study and understand human experience (see Stanley, Barker & Edwards, 2013)¹. And thirdly I have attempted to integrate Buddhist theory and practice into my own therapeutic work, training and writing, which involves bringing it into dialogue with existential-humanistic and social constructionist perspectives. This has culminated recently in my own book exploring current versions of mindfulness and setting out a proposal for a more critically informed and socially engaged mindful therapy (Barker, 2013b), as well as general audience writings exploring romantic relationships from a mindful perspective (Barker, 2013a).

I am aware of the gaps in my own knowledge and experience given that I am not, by any means, a Buddhist scholar. Nor, despite my background in psychology, do I have the in-depth knowledge of cognitive-behavioural psychology or neuroscience that many contributors to these debates have. Therefore I apologise in advance for the necessary oversimplifications in the following arguments. I recognise, for example, that some western authors on mindfulness have engaged with social context and with the tensions which I explore here (e.g. see Williams & Kabat-Zinn, 2011) although such engagements do not always filter down to mindfulness practices in settings which have historically employed medical and/or cognitive-behavioural therapies, which are what I am generally speaking of when I refer to 'western mindfulness'. Additionally, I simply cannot do justice here to the diversity present in the vast array of forms of Buddhism which exist now and historically when I speak of 'Buddhist philosophies'. Finally, of course, I am aware of the range of 'western psychotherapies' which exist which – to a greater or lesser extent – critically engage with the project of diagnosing and treating disorders. Therefore I have attempted to make such generalisations as cautiously as possible, and I hope that the reader will forgive the occasional lapse into polemic, or lack of appreciation for the diversity which exists within the approaches and philosophies which I am referring to, whilst finding it useful to imagine what a more explicitly social

form of mindful therapy would be like within their own arenas.

Western therapeutic approaches to suffering

Broadly speaking, western psychotherapy, psychology and psychiatry regard human distress as a problem which requires fixing with treatment. The focus of the endeavour for the past century or more has been on determining the various different kinds of distress that people experience; categorising these as disorders, abnormalities, or mental illnesses; locating their cause (in their neurochemistry and/or thought processes, for example); and developing physical and psychological treatments with the aim of curing the problems and ameliorating the distress. So, for example, a cluster of symptoms whereby a person has low mood, feels tired, and thinks badly of themselves, may be classified as 'depression', located in their levels of serotonin and/or tendency towards negative self-attributions, and treated with 'anti-depressants' and/or cognitive-behavioural therapy (Pilgrim, 2010).

Such an approach – echoed in wider societal understandings of mental health (Barker, 2011a) - involves fixing the person as their problem: it is something that they *are* or something that they *have* as an internal aspect of who they are, like a personality trait or other individual characteristic. So we divide people into the emotionally, psychologically, or mentally well and unwell, and consider them as *being* depressed, psychotic, or personality disordered, or as *having* anxiety, a paraphilia, or a sexual dysfunction.

Such categorising relates to the ways in which human distress is understood by such approaches to mental health: generally it is located within the person and the focus is upon internal (biological and/or psychological) causes. Thus the western scientific model of cause-effect relationships is applied to human experience as it is assumed that each emotional state or behaviour will have an identifiable cause, probably in internal cognitive processes. This is a dualistic approach which regards causes and effects, minds and bodies, thoughts and behaviours, emotions and cognitions, and individuals and other individuals, as separable and as having the capacity to act upon each other in cause-effect relationships.

So, for example, in the arena of sex therapy, a person may come to a psychotherapist or counselling psychologist saying that they are unable to achieve an erection. They will be

categorised as having 'erectile dysfunction', and as being sexually disordered. This will be regarded as an effect with an underlying cause: most likely a physiological condition of the blood vessels of the penis or a psychological issue relating to anxiety around sexual performance. This may be treated with a PDE5 inhibitor drug and/or with cognitive-behavioural therapy to challenge negative automatic thoughts and to reduce anxiety about sex, perhaps through gradually building up to penetration via other forms of physical touch to increase confidence in the ability to sustain an erection.

When it comes to difficulties in a relationship beyond the sexual arena, relationship therapists are less likely to diagnose an individual (although some diagnostic categories, such as personality disorders, do include relationship problems as criteria). More likely it will be the relationship that is viewed as dysfunctional or classed as a 'relationship problem'. The cause of the problem will still be internally located, often within the thought processes of the individuals, but also within the dynamic between the people in the relationship. Thus there is some sense of people as interconnected, although the couple unit is still treated as relatively separate from the social world in most therapy. The focus of therapy depends upon the therapeutic approach taken, with humanistic, psychodynamic and systemic approaches being as common as CBT in this areaⁱⁱ. Treatment might involve, for example, shifting the attributions that each member of a couple makes about each other (so that they reverse the tendency to blame good behaviour on external factors and bad behaviour on internal ones), providing communication skills training, or bringing dynamics out into the open (for example if one person's nagging tends to result in the other's withdrawal, which results in the first person pushing harder, etc.). There may be some exploration of the background of each person which led to their characters developing in the ways they did.

Western mindfulness: Perpetuating not problematizing?

Considering the most popular forms of western mindfulness that have emerged, and reached prominence, in the past couple of decades, it seems to me that these add some of the key practices and theories of Buddhism to western psychotherapies, but sometimes fail to engage with the challenges that Buddhist philosophies pose to the popular psychological understandings of human experience and distress outlined above.

These mindfulness therapies most frequently add mindfulness to cognitive-behavioural therapy (CBT), an approach which is rooted in cognitive experimental psychology with its emphasis on determining causes of human behaviours, and its focus on the individual human being (in comparison to the wider social focus of sociology, or cultural studies, for example). We can see the predominance of such an approach in the mindfulness research which has been published to date, after the explosion of interest in this topic a decade or so ago. The vast bulk of this research has concentrated on determining an operational definition of mindfulness; measuring the degree of mindfulness a person has; finding out whether mindfulness therapies are effective at decreasing problems such as depression, stress or pain; and examining how mindfulness practice works in the brain (Cohen, 2010)ⁱⁱⁱ.

Therapeutically these western mindfulness approaches involve introducing clients to meditative, and other, practices which cultivate the ability to bring non-judgemental attention to the present moment, rather than constantly evaluating experience and/or becoming distracted by thoughts of the past or the future. However, such techniques are generally introduced as a way of treating specific 'disorder's or 'dysfunctions' (such as depression or anxiety) and therefore still involve separating out and addressing different forms of distress which are regarded as something intrinsic to the individual.

The focus of such mindfulness approaches is also internal, as the causes of distress are located in the individual's relationship to their thought processes and/or emotional states. The aim of mindfulness practice is generally upon shifting habitual mental patterns and changing how we relate to experience by developing the capacity to be in the present moment rather than ruminating on the past or focusing upon achieving future goals (such as feeling differently). It also involves a shift from avoiding experience to approaching it (Segal, Williams & Teasdale, 2002); from changing things to accepting how they are (Hayes, 2005); and/or from a threat-based approach to a more compassionate approach to experience (Gilbert, 2010)^{iv}. There is little engagement, across the literature on mindfulness, with the context in which distress occurs, or critical consideration of the western psychological/psychotherapeutic ways of understanding humans and their distress which underlie such approaches to mental health.

Returning to sex and relationship therapy then, a western mindfulness approach to the same issue

that we considered above would generally still classify the person as having 'erectile dysfunction' and emphasise the role of psychological factors in causing such problems (after ruling out any underlying physiological problem). However, rather than focusing on reducing anxiety about sex and increasing confidence, it might concentrate more upon tuning in to bodily responses and cultivating the ability to be in the present moment rather than ruminating over past experiences of poor performance or worrying that it will go wrong this time. Mindfulness exercises such as breathing meditation, paying attention to body sensations, and observing thoughts coming and going without judgement would be added to more conventional education about sexual functioning (e.g. Brotto, Krychman & Jacobson, 2008; Goldmeier & Mears, 2010). Therapy might also involve challenging of negative thinking patterns and sexual arousal exercises, and the client would be encouraged to approach the anxiety-provoking situation rather than avoiding it (see Brotto & Barker, 2013, for a number of articles applying western mindfulness to various sexual dysfunctions).

Western mindfulness approaches have been applied less to relationship therapy than they have to sex therapy so far. However, work that has been conducted in this area is similar to that in the area of sexual dysfunction in that it generally retains conventional understandings of relationship problems whilst adding on mindfulness techniques as a way of addressing these. For example, Carson, Carson, Gil & Baucom (2004) base their application of mindfulness to relationship therapy on the argument that 'healthy individual functioning is important to successful marriages' (p.472). This retains the focus on internal individual causes of problems - or their lack - not to mention equating relationships with marriage and taking for granted what it means for one to be successful (see below). In their programme, standard western mindfulness techniques and explanations were added on to a pre-existing relationship course which included the kinds of skills instruction and couple exercises common to relationship therapy.

Social mindfulness

This section will outline a social mindfulness perspective as a possible alternative to the most popular forms of western mindfulness outlined above, before applying this in detail to sex and relationships in the remainder of the paper.

Social mindfulness has emerged in the last few years in the United Kingdom out of a critique of the ways in which western psychotherapy and psychology has engaged with Buddhist philosophy to date (Stanley, 2012). The alternative form of social mindfulness which is put forward attempts to do two things differently:

(1) To engage more fully with the Buddhist philosophies which mindfulness was initially embedded within, and with current Buddhist thought and practice, all of which integrates the social aspects of experience more fully than current western mindfulness given its non-dualistic understanding of human being.

(2) To bring such Buddhist theories and practices into dialogue with western approaches which engage explicitly with the social level of existence, such as sociology, cultural theory, existential philosophy, and critical psychology. This involves drawing upon the work of writers such as Beauvoir, Foucault, Butler and Deleuze who emphasise the embodied nature of experience and the role of social power in the construction of identity, for example.

Table X, below, outlines the different conceptualisations that social mindfulness has: of distress, or human beings, of the causes of experience – including distress, and of the appropriate way of therapeutically engaging with distress. Each of these points will be developed in the remainder of this section of the paper.

	Western mindfulness approaches	Social mindfulness approaches
Distress	A problem to be treated and eradicated, albeit sometimes in different ways to standard psychotherapy	Inevitable and therefore to be embraced as part of life
Human beings	Separate individuals who may be ordered/disordered, healthy/ill, normal/abnormal	Interconnected beings, inseparable from each other and the world they occupy

Cause of experiences	Internal biological and/or psychological factors	No causes but rather a constant coarising of a complex interaction of biopsychosocial processes
Cause of distress	Habitual ways of relating to thoughts, feelings and sensations	Craving for things to be otherwise, self-monitoring based on societal norms
Therapy	Techniques in which we non-judgementally attend to the present moment	Critical engagement with the way discourses operate through us via mindful practices and reflection

Table X: Key differences between popular western mindfulness approaches and the social mindfulness approach

As we have seen, broadly speaking western mindfulness adds a form of mindfulness onto existing western psychotherapy rather than allowing mindfulness - and its underlying philosophy - into a dialogue which might challenge the assumptions implicit within western psychological and therapeutic approaches^v. Perhaps the most obvious tension here is the fact that western therapies view human distress as something to be treated and eradicated – a problem to be fixed – whilst Buddhist philosophies generally regard distress of various kinds as an inevitable part of human being. Buddhist mindfulness practices are part of the path towards accepting that our suffering is rooted in our very attempts to avoid and eradicate distress. We practice mindfulness in order to observe our habitual tendency to try to get all of the things we want and to avoid or get rid of all of the things that we don't want. In slowing down and observing such craving approaches on an everyday level we can see how our suffering is rooted within them.

Western mindfulness approaches do engage to some extent with these understandings, for example by advising approaching difficult experience, such as fear and anxiety, rather than

avoiding them (Crane, 2009), and by cultivating the capacity to accept experience as it is rather than engaging in goal-directed attempts to change it (Flaxman, Blackledge & Bond, 2011). However, there is little engagement with the conflict inherent in the fact that this is often still done in the name of treating 'disorders' such as depression and anxiety, sexual 'dysfunctions', or relationship 'problems'. We remain at risk of endeavouring to escape or avoid distress rather than taking seriously the inevitability of suffering in life and addressing how we engage with this.

For this reason – and because of the concentration on finding internal causes of suffering - the client in western mindfulness therapy may well still feel as though they are lacking or flawed in some way *because* they are struggling. Western therapy, from a Buddhist perspective, could be regarded as implicated in suffering, because it reinforces and perpetuates the idea that struggling is pathological, rather than normal, and that it can be eradicated through the therapeutic process, or through becoming mindful enough. Despite its emphasis on *being* rather than *doing*, some forms of western mindfulness are in danger of sneaking back in the goal of removing all pain from life (see Magid, 2004). They may well contribute to client's self-blame and suffering when mindfulness – just like everything else they have tried – fails to accomplish the total eradication of pain.

If we consider the wider sociocultural context in which western psychotherapy has developed, and in which western mindfulness has been embraced, these paradoxes become more explicable. Psychotherapy emerged in the 'panopticonic' society which resulted from industrialisation, secularism, individualism, and consumer capitalism (Foucault, 1975). As in the perfect panopticon prison where the prisoner knows that they may be watched by the guard at any time and therefore starts to police their own behaviour, modern society encourages people to continuously monitor and police themselves and others. Via mainstream media and the babble of everyday conversation a sense of anxiety is created about things we lack (e.g. beauty, youth, love, or pleasure). We are encouraged to compare our individual, atomised, selves against (idealised) others and to find ourselves wanting (Barker, 2013a). We are then required to buy products, read magazines, watch television programmes, and engage in various forms of self-improvement, in an attempt to fix ourselves. This is doomed to failure because there will always be further lacks to uncover as we continue to scrutinise ourselves, our bodies, our relationships, and our lives, for the ways in which they are wanting (Gergen, 2000).

Psychotherapy can be seen as part of the panopticon, encouraging us to attend to our 'neuroses' or 'negative thoughts' and to engage on an endless project of self-perfection in a desperate attempt to be 'normal': to fix the disorders and dysfunctions that psychotherapy told us that we had in the first place (Kutchins and Kirk, 1997). Also given the lack of disclosure by the psychotherapist it is easy for the client to assume that the therapist is another normal person who they are flawed in comparison with (Barker, Vossler & Langdrige, 2010).

Given this, it is all too easy for mindfulness to simply become the new way in which we are flawed: not mindful enough, or not happy in the ways in which the positive psychology movement suggests that we would be if we were more mindful. Similarly it is easy for meditation and other practices to become the latest commodity to buy (Carrett & King, 2005), and a stick to beat ourselves with as we realise that we are not doing it enough, or properly, or whatever we would need to be doing in order to finally stop struggling (Chödrön, 1994).

The western mindfulness emphasis on paying non-judgemental attention to the present moment as an internal individual solution to psychological difficulties risks missing the wider social context in which such difficulties emerge. This is true of situations of alienation, stigmatisation and oppression which statistics on different levels of diagnosis across gender, race, sexuality etc. clearly implicate in distress (Barker, 2010). It is also true of the wider western craving-culture in which we are encouraged to relate other people and the world in precisely the attachment/aversion ways in which Buddhism suggests creates suffering (Barker, 2013b).

Buddhist philosophy is also non-dualistic. This is in tension with the models of human being inherent in most psychological therapies, and in current western understanding more broadly, which, as we have seen, separate out: minds and bodies, thoughts and feelings, and self and other. The panopticonic view which regards us as atomised beings with individual identities to be monitored, compared against others, and improved, is alien to much Buddhist philosophy as I understand it (from my reading of the work of Buddhist scholars such as Batchelor, 1997, Bazzano, 2012, and those who contributed to the collection by Williams & Kabat-Zinn, 2011). This – if engaged with fully – would point to a further, potentially highly valuable, way of addressing suffering: That is by questioning the notion of static, separate and bounded individuals who can be evaluated in such ways, and instead emphasising the interconnectedness and intersubjectivity

inherent in being-in-the-world-with-others (Nhat Hanh, 1975; Gergen, 2009).

Non-dualistic Buddhist philosophy is consistent with more recent western critical theory about health which stresses that we are embodied beings (not separate minds and bodies) and that all experience is simultaneously biopsychosocial (or sociopsychobio), and that it would be impossible to tease these elements apart (Fox, 2012). We are embodied biological beings *and* psychological experiencers *and* inextricably located in our social worlds. As Steven Batchelor explains the Buddhist concept of contingency:

We have been created, molded, formed by a bewildering matrix of contingencies that have preceded us. From the patterning of the DNA derived from our parents to the firing of the hundred billion neurons in our brains to the cultural and historical conditioning of the twentieth [now twenty-first] century to the education and upbringing given us to all the experience we have ever had and choices we have ever made: these have conspired to configure the unique trajectory that culminates in this present moment (Batchelor, 1997, p.82).

This 'bewildering matrix' renders nonsensical simplistic splits like mind/body, nature/nurture, or hard-wired/chosen behaviours. It also challenges the common psychological assumption of cause-effect relationships, which are overly simplistic when it comes to open systems like human beings. Again there are moves in western theory and science away from such simplistic understandings which resonate with Buddhist perspectives (e.g. see Fox, 2012; Varela, Thompson, & Rosch, 1991), whilst much mainstream psychological and psychotherapeutic work, including much of the research on mindfulness retains such assumptions.

In the final two sections of this paper I will illustrate what a social mindfulness therapeutic approach to sex, and to relationships, might look like. This hopefully illustrates the implications of taking seriously the ideas that suffering is inevitable, that it is rooted in craving patterns of attachment & aversion which current culture encourages us to pursue, and that humans are embodied and interdependent biopsychosocial beings (non-dualism). Under such an approach, the same mindful practices which are integrated by western mindfulness therapies take on a somewhat different aim

and meaning, in that they reveal not only individual psychological habits of thought, but also – and inter-relatedly – the ways in which societal understandings operate through us in our patterns of bodily-emotional-thought responses (see Wetherell, 2012).

A socially mindful sex therapy

As previously mentioned, conventional sex therapy diagnoses people as having 'sexual dysfunctions' such as erectile dysfunction, premature ejaculation, vaginismus and other kinds of sexual pain, low desire or inability to orgasm. These are regarded as problems which require fixing by determining their physiological and/or psychological causes and addressing these. For example, common treatments include drugs and CBT techniques which target the cognitions underlying anxiety or low desire and/or the sexual behaviours (gradually building up to erections and orgasms) (Barker, 2011b).

Thus far, the research literature arguing for the involvement of mindfulness in sex therapy has focused on the potential of mindfulness practices to achieve the same aims as conventional sex therapy (sexual desire, lasting erections, penetration, and orgasm) (Suttie, 2013). Some have pointed out the commonalities between mindfulness and the sex therapy staple of sensate focus whereby the emphasis is taken off genital sex and partners attempt to be present to all sensations they are experiencing (Goldmeier & Mears, 2010). However, such gradation techniques often sneak back in an overall goal of penis-in-vagina penetration and/or orgasm and the implicit assumptions inherent that this is what constitutes 'good' or 'proper' sex (Barker, 2011b). Some have even suggested that mindfulness could enable people to have penis-in-vagina sex when they are not aroused, or when finding it painful, due to an openness to all sensations which is part of why mindfulness is a helpful practice for chronic pain (see Brotto & Barker, 2013).

Such an approach is problematic in both its insistence on a certain form of sex and its failure to understand the embodied nature of human beings. More existential-humanistic therapists have argued that we need to listen to bodies which are refusing to be penetrated, to become erect, or to orgasm, as there may well be good reasons for this (Barker & Langdrige, 2013). For example, young women with vaginismus are often involved in some degree of self-objectification and trying to be what others want them to be. The body's refusal to be penetrated could thus be regarded as

useful and explicable, and attempts to achieve penetration through gradual insertion of thicker dilators (classic sex therapy) or mindful practice to deal with pain, both seem deeply problematic in this light (Barker, 2011c). Similarly penises which fail to become erect or to ejaculate, may be communicating important things about the pressures around masculinity, the relationship the person is in, or wider anxieties about performance or success (Kleinplatz, 2004). Given the non-dualistic philosophy which mindfulness is embedded in, a holistic biopsychosocial form of therapeutic engagement which took account of these psychosocial meanings would seem to be more appropriate.

Any mindful sex therapy which sneaks in the aim of a particular kind of sex risks being goal-oriented rather than pleasure/experience-oriented. Social theorists in this area have pointed out the heteronormativity and gender bias involved in what is considered to be the appropriate goal of sex therapy with its insistence on erect penises reaching orgasm through penetration of vaginas (Barker, 2011b). Such an approach is in contradiction with mindfulness approaches which are aware of the problems inherent in a goal focus which create gaps between where we are and where we want to be (Crane, 2009).

Mindful sex therapy needs to take seriously the implications of - and reasons for - the mindful emphasis on being present to experience and on shifting from a goal-oriented 'doing' mode to a 'being' mode. It is not enough to teach mindful practices as an addition to conventional goal-directed therapy.

A more social form of mindful sex therapy would take the present-focus of mindfulness, not as a way of moving towards standard sexual goals, but rather as a starting point for critical engagement with the social context in which sexual problems emerge. This might include the constructions of femininity or masculinity mentioned above, the ways in which we are alienated from our bodies, or the current imperative to be sexual in particular ways and the self-monitoring and judgement that this leads to.

Mindful practice can be employed to invite clients into a phenomenological exploration of their lived experience of sex. Instead of engaging in sex with particular aims they can begin to bring mindful attention to sex and thus notice what is happening in terms of their sensations, feelings and thoughts during the experience.

One activity which I have found useful is to encourage people to pick a particular kind of sensual, erotic, or sexual experience which they have experienced as both fulfilling and not fulfilling. This could be a sexual practice with another person, masturbation, flirting, receiving a massage, cybersex, or anything else that they would put into this category. People then remember the experiences, in rich detail, through the kind of spacious attention which takes in everything equally, writing a thorough description of both the fulfilling and not fulfilling versions of the experience^{vi}. Discussion then focuses on the difference between the two versions.

What generally emerges from this comparison is that the differences are akin to the differences between engaging in an experience more or less mindfully (see Barker, 2011d). In the fulfilling experience people are present rather than worrying about previous experiences or thinking about what is coming next. They generally feel engaged in the flow of what is happening rather than finding themselves distracted. They feel embodied rather than experiencing a separation of body and mind whereby they are evaluating how they look in this position or whether their bodies are responding or performing 'right'.

It is useful to engage in a reflective exploration of what is 'getting in the way' in the non-fulfilling experience and causing those jagged edges which disrupt an easy sense of 'flow'. Often the main blockage is the babble of monitoring self-talk which the person is engaged in during sex. This is embedded within the social understandings which surround us about what we *should* be doing: the media images of sex we've been bombarded with, the script for 'successful' sex, and the comparisons we make against imagined others.

If our mindful observations of sexual experience do lead to the conclusion that our struggles with sex are interwoven with the social context within which we are embedded, then the therapeutic endeavour becomes a double-pronged approach. First we attempt to bring a more mindful form of attention to the sex we are having. Second we critically engage with those social understandings such that we may see them more clearly for what they are and how they operate through us. Through this we may become able to treat these understandings more lightly rather than becoming attached to them and caught up in their story.

What we likely find through such a critical engagement is that our approach to sex is shot through with craving patterns of attachment and aversion, all of which are reinforced by the world around

us (Loy, 2008) including conventional psychological and psychotherapeutic understandings of sex. Both everyday understanding and psychiatric diagnosis divides sex into normal and abnormal, functional and dysfunctional, and places huge importance on 'getting it right'. Therefore, during sex we are likely trying hard to match up to 'good sex' (which happens this often, lasts this long, requires men to naturally know exactly what to do, and results in erection, penetration and orgasm). Anything without these elements is judged inferior, dysfunctional, or even not sex at all. There is also fear of straying into 'bad sex' which is still pathologised as 'paraphilic' (any kind of excitement at certain sensations or materials, at being watched or watching others, or at mixing sex with pain or power). We are attached to normal, functional, good sex, and attempt to avoid/eradicate abnormal, dysfunctional, bad sex. We walk a fine tightrope between the two as sexual norms and mores shift rapidly and what constitutes great sex involves straying just far enough into the dangerous, exciting stuff, but not too far (Barker, 2013a).

A Buddhist approach to sex would involve noticing and challenging such internal, and social, patterns of attachment and aversion which make it nigh on impossible to be present and fulfilled during sex. A more mindful engagement would involve opening to our sexual and other desires and to the embodied conversation which is happening between partners during sex. This does not mean behaving unethically, given that, in Buddhism, mindfulness is intrinsically linked to compassion and commitment to ethical behaviours. We would attempt to tune in to both our own bodies and desires, and to those of our partners. This would include questioning the current imperative to be sexual – in the narrow way in which this is defined – at all (Richards & Barker, 2013).

We should encourage clients into a full biopsychosocial engagement in sex, considering their lived experience in detail and how it relates to the social understandings around them which operate through them (in their psychological experience of self-monitoring) and play out on and in the bodies of themselves and their partners. Part of this certainly involves engaging in mindful practice. Mindful sex becomes more possible if we cultivate the ability to be present to experience and to notice and attend to all aspects of it in other, less loaded, areas of life such as washing dishes, driving or sitting. Practices like body scan and walking meditation may well enable us to tune into our bodies better. Here the aim would be to realise that we are embodied, rather than to trick or

force the body into doing what is socially expected of it through practices which enable us to relax more or to handle pain and displeasurable experience.

More radically still, we may find that such mindful engagement with sex enables us to bring the same qualities of noticing and critical social engagement to other aspects of our lives and to reach a wider understanding of the ways in which the social operates through us and can be resisted. This is something that I will return to in the conclusion to the chapter.

A socially mindful relationship therapy

We have seen previously that relationship therapy is generally somewhat less internally-focused than sex therapy, due to being less mired in diagnostic categories and attending more to the dynamics between the people in a relationship. However, relationship therapy is still generally goal directed, with the aim of helping couples in distress to resolve their issues and to find ways to stay together (Relate, 2013). This aim fits with wider government and cultural contexts which regard divorce, separation, single parenting, and living alone as social ills and coupledness, monogamy, marriage and the nuclear family as the 'right' way to relate and to bring up children. There is rarely an exploration, in relationship therapy, of this wider social context in which we experience our romantic relationships, nor of the relatively recent emergence of the romantic partnership, love marriage and nuclear family compared to the massive diversity of ways of relating that have been present across history and remain so globally (Barker, 2013a). For example, being romantic or sexual with more than one person is generally only understood in the context of cheating and infidelity, as an inevitable danger to the couple unit, and something to be avoided or eradicated, rather than recognising the global minority status of monogamy or the diversity of open non-monogamies which exist (Barker & Langdrige, 2010).

Like sex therapy, western mindful approaches to relationship therapy so far generally retain the goals of resolving issues internal to the couple and enabling them to stay together. They suggest that this could be achieved through mindful practices, for example by facilitating couples to listen to each other, to be more compassionate, and more present to each other. There is little or no critical engagement with what kind of relationship we are aiming for and why, or what makes a 'successful' relationship (e.g. see the concept of the 'mindful couple' put forward by Walser & Westrup, 2008).

The neglect of the current social context is a serious one given that this has a key role in creating relationship distress. As Loy (2008) points out, romantic relationships have become bound up in our personal happiness and fulfilment in recent decades: people look to romantic relationships to reach a permanent state of 'happily-ever-after'. At the same time, people are living longer and are also encouraged to develop and reach their own individual goals in life, with greater gender equality meaning that both people in most couple relationships are focused on being personally fulfilled as well as having a 'good relationship'.

As with sex, this situation exacerbates the patterns of attachment and aversion to which Buddhist philosophies suggests that we are already so prone (see Batchelor, 2007; Chödrön, 2001). In romantic relationships this means that we devote much time and energy to finding The One perfect person who will complete us and always love us. When imperfections inevitably emerge we either continue our quest in the form of serial monogamy or secret infidelities where we search for what our current relationship is lacking. Alternatively we remain monogamously together with that person and collude in presenting an illusion of perfection to everyone else (which perpetuates the myth for them), whilst privately struggling with failure of the relationship to meet our unrealistic expectations. This may take the form of resigned disillusionment, or cycles of conflict as we fight against perceived flaws or being seen as flawed by the other person. Many people stay in painful and damaging relationships partly due to the pressure to be in the relationship, or the conviction that they have found the 'right' person and there won't be anybody else for them (Barker, 2013a).

As with sex therapy, social mindfulness can help people to recognise the ways in which such social discourses, scripts and imagery operate through them. For example, I have found an adapted form of Pema Chödrön's (1994) description of *tonglen* practice to be extremely helpful in noticing the expectations and assumptions around romantic relationships which are in play at times of conflict or disappointment. In this practice we deliberately engage with difficult and painful emotions rather than avoiding or attempting to escape them. We use these experiences explicitly to connect with the person who we are struggling with in our shared vulnerability.

Through such practices we may become increasingly aware of the ways in which we look to romantic relationships to validate ourselves and to prove that we are okay really. Unfortunately, however good our partners are at this (or we are for our partners), our own secret convictions, from

being embedded in self-monitoring culture, that we are really fundamentally lacking in some way bubble up. We become resentful of our partner for not keeping this at bay; desperate at our own inability to keep the 'bad' sides of ourselves hidden; or angry at our partner for revealing their own imperfections. At such times we easily start to look elsewhere and engage in either/or thinking: Either they are perfect and we must stay together or they are imperfect and we must break-up; either this is their fault or it is our fault; either we are the good guy or the bad guy (Barker, 2013a). Writers such as Chödrön (1994) and Wellwood (1996) offer alternatives to such patterns which point the way to what a more socially mindful form of relationship therapy might look like. We can slow down and notice, for example: the desires for a partner to be everything to us; either/or thinking about whether we are together/separate; ideas that they belong to us or that we need to fix ourselves in a particular way for them; or the tendency to quantify what we give them and they give us. We can see how angry, insecure and jealous experiences are shot through with such flickering thoughts and how these, in turn, come from the social milieu we are embedded in: how we have learnt to respond in this way from a million love songs, romantic comedies, magazine articles and soap operas (Barker, 2013a).

Instead of continuing the pattern of defensively protecting our vulnerabilities and searching for the perfect relationship which will validate us and keep us safe, we can instead open up to communicating and attending to these vulnerabilities. As Wellwood (1996) suggests, relationship therapy can become a process of exploring the ways in which we want our partners to see us, and the ways in which we fear being seen, and embracing the latter as part of us rather than pushing it away.

Such a process necessitates a wider critical consideration of the social context in which we are encouraged to view romantic relationships in such problematic ways, and to develop such impossibly high expectations and restrictive assumptions of what a good relationship looks like. Such critical explorations may also involve questioning why only certain kinds of relationships are socially accepted and encouraged, and others excluded or prohibited to a greater or lesser extent (same-sex romantic relationships, romantic relationships between more than two people, non-romantic relationships such as close friendships between men, non-sexual relationships, etc.). Instead of seeing the romantic relationship as the only vital relationship in our lives, which requires

constant monitoring and evaluation, and seeking therapy if it goes 'go wrong', we might shift to viewing ourselves as being in multiple relationships of different kinds all of which are valuable (Barker, Wilkinson & Heckert, 2013). This includes relationships with all the other humans who we live, work, and connect with; with animals; with the world; and with ourselves. Such an approach is less dualistic in relation to self and other than conventional relationship therapy, instead regarding us as being inevitably interconnected.

Under such an understanding the goals of relationship therapy shift from a scrutiny of the dynamic between us and how it is failing, to an exploration of how wider pressures operate on the relationship. Recognising that we are inevitably in relation with each other may take the pressure off the either/or of 'staying together' or 'breaking up'. We might consider how we can open up to all of the relationships in our lives rather than placing so much emphasis on this particular one. All of this can move us from a constant turned-inwards mode of monitoring and policing ourselves and our romantic relationship in the attempt to present a perfect face to the world, to a more turned-outwards mode where we are more open about our vulnerabilities and frailties and more engaged with all others around us.

Conclusions

In my view a fully socially mindful engagement with sex and relationships is non-dualistic in that it does not separate out psychological experience from social context, and therefore challenges any entirely internal explanation of distress. Such an approach calls upon us and our clients, to think critically about the social messages which are operating through us and to start to 'swim against the stream' of our habitual ways of being (Batchelor, 2010, p.125). As we have seen, in relation to sex this involves questioning the divisions between 'good' and 'bad' sex commonly accepted and perpetuated by psychiatry, psychology and psychotherapy. In relation to relationships this involves questioning the dominant view of romantic relationships and the prevalent notion that we should constantly monitor ourselves and our relationships in order to portray a perfect, or normal, face to the world.

If our therapies become non-dualistic we might find ourselves in a position to better see the role of sociocultural forces and power dynamics in our client's distress. We might be able to better

understand the ways in which our own psychologies and therapies are sometimes implicated in exacerbating, rather than ameliorating suffering: through their place in self-monitoring society, for example, or the definitions of functional/dysfunctional sex and successful/unsuccessful relationship that they perpetuate.

Given this knowledge we need to ask whether it behoves the (socially) mindful therapist to engage on a social, as well as an individual therapeutic level. My own belief is that we should not simply be applying mindfulness with individuals or groups, but rather we should be raising wider, vital questions in the worlds of therapy and psychology about how sociocultural contexts create conditions of sexual, relational, and other, suffering, and how psychotherapy and psychology may be complicit in this in its categories and treatments.

The mindful therapist would also be a social activist, as many have argued the historical Buddha was, whose work would ideally leave both psychotherapy and the wider world irrevocably transformed.

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Biography

Meg Barker is a senior lecturer in psychology at the Open University and an existential/mindful therapist working in sex and relationship counselling. Meg has published co-edited collections on non-monogamies and sadomasochism with Darren Langdrige and they also co-edit the journal, *Psychology and Sexuality*, with Taylor and Francis. Meg's research on sexualities and relationships has been published in several journals and books and has culminated recently in a popular book called *Rewriting the Rules*. Meg also has books for therapists and counsellors on gender and sexuality (co-authored with Christina Richards), and on mindfulness, both coming out in 2013.

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- i See also the Social Mindfulness website at <http://socialmindfulness.wordpress.com>.
 - ii Of these, some systemic therapies are more critical and aware of wider social contexts, as will be explored in the later section of the chapter. The other approaches still tend to locate problems internally within individuals and the dynamics between them due to their internal psychologies.
 - iii For a full overview of such research see the chapter on this topic in Barker (2013b). There are, of course, differences and tensions between the various types of research in this area (e.g. outcome research, measuring mindfulness as a cognitive capacity, and neuroscientific research). However, I think it is fair to say that the vast majority of these generally accept the cause-effect model of western science referred to here.
 - iv Of course again we can see that there are differences in emphasis between the different forms of western therapy which have drawn on mindfulness, and many useful approaches have emerged from the engagement with Buddhist thought. However, it seems fair to say that there is relatively little engagement with the social context in which people are situated or the circulating cultural messages and narratives that they are exposed to in these forms of therapy.

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- v Such a dialogue is beginning to happen and the special issues of Contemporary Buddhism edited by Williams & Kabat-Zinn (2011) offers a much more in-depth consideration of commonalities and tensions between western mindfulness and Buddhist philosophy.
 - vi For those less comfortable with writing, drawing, making collages, verbal description, or other forms of expression could be used.