

Developmental Psychopathological Perspectives on Sexually Compulsive Behavior

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Introduction

The developmental factors contributing to sexually compulsive behavior, paraphilias, and sex offender behavior have been poorly delineated [1]; and that which has been written on the subject is stuck in a conceptual quagmire. Marshall [2], states:

“It is important to note that our theory suggests that a failure to attain intimacy in relationships is but one aspect of the development and maintenance of sexual deviance. We have at other times, pointed to sociocultural factors [3], the role of pornography [4], and biological processes and interaction as well as conditioning [5] and developmental experiences [6].”

In other words, many different factors may contribute depending on the clients. How best to embrace and incorporate these factors into a successful treatment approach? A developmental psychopathological perspective may provide the answer. It is a robust conceptual frame that departs from such traditional models of uni-dimensional static “causes” of a disorder [7] and instead postulates a developmental trajectory for a symptom in the evolutionary context of the individual attempting to adapt [8]. Critical life events precipitate other positive or negative life experiences or circumstances then mitigate, thereby increasing or decreasing the resulting degree of disability and the likelihood of symptom emergence. Adaptation continually unfolds within an ever-changing context, allowing for developmental deviation or for amelioration of an ontogenetic process [9].

Maladaptation can result from different developmental pathways, which are probabilistically related to disturbance. Individuals beginning on similar paths may diverge, manifesting different symptoms of psychopathology. Thus, despite marked initial deviation, the capacity to rebound is mediated by prior adaptation, and evolves over time within the total framework of developmental influence. To treat the client according to this model, the clinician

must endeavor to construct or reconstruct all contributing biological, psychological, and social trends from an individual's past and present to understand their coalescence into the individual's current functioning.

To illustrate, I was recently involved in a court case in which, 20 men came forward after the public disclosure that a priest had molested children in their church for many years. As boys, they had known one another and had witnessed their friends being molested at or near puberty. None of the boys had ever been to a mental health professional. All 20 men were severely impaired with Axis I and Axis II diagnoses, but none had attributed their psychiatric symptoms to their repeated molestations until they heard the newscast. All the men had relational and sexual difficulties, ranging from pedophilia (2), ego dystonic homosexuality (2), hyposexuality (8), hypersexuality (6), and asexuality (2) [10]. Viewed through this conceptual lens, one could conclude that a virulent event, such as a priest molestation, is of such magnitude that it injures almost everyone, but the manifestation of that injury is quite variable and related to a multitude of other factors. We do not know, for instance, how many men were molested but *did not* come forth or whether they all have such severe symptoms.

In the backgrounds of these boys, most showed social isolation and serious problems in relating to others. More than 90% had no friends. Only 20% of this sample thought that their parents treated them well. None, though, had difficulties with the law beyond drug abuse or alcohol related offences. My search for other contributing influences included a review of the empirical literature. Abel et al, (1985), has noted that 58.4% of sex offenders reported onset of their deviant sexual arousal prior to age 18. Other factors found to be predictive of sexual deviation have included: a history of parental conflict, poor parental supervision, and lack of affection by the mothers [11]. Each of these boys had difficulty transitioning through

adolescence and forming adult relationships, and to different degrees a combination of the above risk factors.

This case illustrates abuse from clergy as one example of a highly pernicious event that will result in a variety of severe adult psychiatric manifestations, including pedophilia in select individuals with a history of prior “at risk factors,” and that influences such as social isolation can either increase or decrease the outcome. This paper will review some of the other sequential developmental factors that might contribute to sexual compulsivity in such biographies. They include: temperament, early attachment, family influences, trauma reenactments, affect dysregulation, social isolation, vandalized love maps, self -formation, sexualization in families and addictive cycles.

Temperament and Sexual Compulsivity

Cloninger (1998) suggests that the relay race of developmental influences begins with temperament. He states, that temperament consists of autonomic impulses in response to basic associative stimuli which give rise to primary emotions such as fear, anger, disgust and determination. Four independent inherent dimensions emanating from discernible brain systems have been distinguished: harm avoidance (anxiety proneness, risk taking), novelty seeking (impulsiveness and rigidity), reward dependency (approval seeking and aloofness), and persistence (determination and fixedness). Cloninger correlates these temperaments with dimensions of character in a step-wise fashion.

Cloninger’s system overlaps with the longitudinal data of Caspi and Silva (1993) in which they isolated temperament patterns of three-year-olds as (a) uncontrolled, (b) inhibited, or

(c) well-adjusted. They then followed the children longitudinally to discover that “uncontrolled” children externalized their problems at age 10 and, at a later age, scored low on constraint. These children described themselves as reckless, careless, and said they enjoyed dangerous activities. The “inhibited,” at age 18, were shy, fearful and ill at ease socially. These temperaments are predictive of the compulsive style (inhibited) of the acting-in individual and the impulsive style (uncontrolled) of acting-out clients as sexual compulsives. In Cloninger’s typology, if it is likely that the individual disposed to be out-of-control sexually is either impulsive (novelty seeking) or compulsive (persistence) at an early age [12], both “uncontrolled” and “inhibited” fit the latter profile of select adolescent sexual compulsives [13]. Disinhibition due to alcohol, drugs or anger has been noted commonly in individuals who are sexually out-of-control [14]. For some individuals, sexually out-of-control behavior is part of general antisocial tendencies [15], along with nonconformity and impulsivity [16]. Though little research currently exists on the topic, it is likely that temperament factors will be important in distinguishing which at-risk individuals will eventually act- out sexually and the ways they act-out. The areas that need study are: the consequences of early impulsivity and compulsivity, which individuals within these categories are at risk for acting-in or acting-out, which individuals are likely to be socially inhibited, and identifying individuals at risk for lack of empathy. Caspi’s work suggests that these characteristics can be reliably measured by age three. It is likely that temperament contributes to some percentage of the variance that explains how individuals with similar trauma may react quite differently.

Attachment and Sexually Compulsive Behavior

Sexually compulsive behavior can best be understood under the superordinate category of courtship disorder [17] or as a “disorder of bonding or intimacy” [18]. Fehrensack, 1988 found

that 65% of 305 juvenile sex offenders showed significant signs of social isolation and had serious problems in relating to others. Thirty two percent had no friends and 34% were more isolated than non-sexual adolescent offenders who were chronically violent. Intimacy disorders have three common deficits [19]: (a) impaired sense of self, (b) difficulty with affect regulation, and (c) injury in ability to turn to others for comfort and safety. Effective treatment of hypersexualities often requires changes in each of these areas. Each of these subtopics will be discussed briefly.

Impaired Sense of Self

In his review of the development of the brain and origin of self, Alan Shore (1994) articulates the initial role of the mother-child dyad elegantly:

“The child’s first relationship acts as a template and it molds the individual’s capacities to enter into all emotional relationships. Development essentially represents a number of sequentially mutually driven infant-care-giver processes that occur in a continuous dialectic between the maturing organism and the changing environment. It now appears that affect is what is actually transacted within the mother-infant dyad, and the highly efficient system of emotional connection is essentially nonverbal”

Thus the mother’s attunement to the child facilitates the experience-dependant-maturation of the neurological hard wiring of the child’s brain, hierarchically from the lower limbic emotional structures, through the midbrain and up to other cortical structures during this early critical period [20]. Therapists are discovering [21] that strong affect is the window into “deep structure” in which core beliefs (schema) and unconscious internal working models shape the love maps during the first ten years of life [22]. More attention is currently being paid to the attachment between infant and caretakers in the first years of life mostly stimulated by the original writings of John Bowlby (1973). Table .1 is a summary of empirically established

attachment patterns. A secure attachment in these early years provides the child the security needed to confidently explore the environment, to develop feeling of empathy for others [24], to have positive self-esteem, and ultimately, to have better quality adult love relationships, friendships and acquaintanceships [23]. Attachment problems can become more likely when there is: (1) disruption in which the attachment figure is perceived as unloving (depressed mothers), (2) parental abuse or when the attachment figure is the source of danger, as well as safety, (3) a subjective sense of feeling abandoned by the attachment figure, particularly at a time of crisis, and/or (4) loss of an attachment figure by death or injury [24]. Individuals adapt to such attachment trauma either by dismissing the need for attachment and potentially, any available connection (avoidants), or by becoming “preoccupied” with their hunger for love but anxious about rejection, as is frequent with so called “sex addicts.” Such individuals are starving for love but confuse genital sexuality with feelings of loneliness and disconnection. The “disorganized” style combines both strategies and is the prototype of “intimacy disorder” in our culture.

Inadequate early attachment bonds are highly predictive of later relationship distress. Individuals rated as “anxious ambivalent” are both starving and fearful of close relationships, while “avoidant” children later often report never having been in love or never having experienced strong feelings of love [25]. Sexuality is generally a manifestation of attachment difficulties, so the “preoccupied” individual can have anonymous sex with multiple individuals in an evening, without feeling sated. The “avoidant” will go out with prostitutes and have mechanical sex without affection or emotional connection [26]. Of recent interest have been individuals assessed with disorganized attachment [27]. The researchers originally identified children who in the “strange situation” at 18 months of age both approached and avoided the

returning parent, and often appeared dazed, confused and apprehensive. The researchers hypothesized that this behavior is related to the parent's struggle with unresolved trauma of their own. Ogawa and Stroufe (2000) [28] also identified a link between disorganized attachment during the child's first 29 months and adult dissociation. Disorganized individuals in adulthood are described by themselves and friends as somewhat introverted, cold and emotionally void [29]; they do not know how to turn to others for help. They lack a "secure base."

The importance of using the lens of attachment theory is that sexual disorders can be understood as a manifestation of pair-bonding, courtship, attraction, love, affection and intimacy. Without adequate parenting, a child grapples with "increased" appetite for nurturing and caretaking, while simultaneously adapting by becoming dismissive of such needs, with expectations of being hurt, disappointed, abandoned and so on. In this way, needs themselves have become "dangerous" and associated with fear. The solution to both needing and fearing is paraphilia. The person becomes aroused by pictures and objects, rather than people, - the fetish distances and provides a ritualistic illusion of control, in what would otherwise be a terrifying situation. The object will not abandon or hurt, and yet provide comfort. The preoccupied individual will no doubt turn to more and more sex to fill the needs for caretaking, while the avoidant will use sexual activity to be alone and disconnect but to still feel alive and experience some affective respite from emptiness through the intense release.

When an individual experiences misattunement with their caretakers during infancy, they fail to establish a secure attachment and the feelings internally of being loveable and entitled to job and connection with others. Injury to this attachment system impairs their ability to "metabolize" stress since humans need to talk to others and receive comfort when overwhelmed.

When there is misattunement with the caretaker, the child actively anticipates their mother's reaction and hence, inhibit or minimize their internal experience of "needing" resulting in avoidance of intimacy. Other children amplify or maximize awareness and the expression of attachment, feeling and needs, in response to periodically getting their needs met. The child hyperactivates his attachment system to capture the mother's unpredictable attention.

Like these infants, sexually compulsive individuals actively maintain the "rules of attachment" laid down in infancy. Some deny their unmet emotional needs by distracting themselves with sexual obsessions. Others are consumed with doubt of the partner's love, and require sex as a constant reassurance of loveability. Thus their sexual behavior ultimately serves the function of in order to preserve unaltered internal working models of attachment.

To change these cemented patterns, the primary focus of treatment needs to be on facilitating the development of secure attachment with self and others. This begins with an attuned relationship with the therapist. The therapist that focus on changing internal working model, will be maximally effective.

Attachment and Self Systems

Disorganized attachment results in individuals who turn to paraphilia as an active survival strategy to cope with the inability to articulate internal states and turn to other people for comfort. Clients unconsciously deploy their attention to sex in order to shore up and justify preexisting expectations of unresponsive and unpredictable caring. Individuals actively use paraphilia to avoid anticipated rejection in intimate relations. The result of disorganized attachment is that it leads to the development of segregated, dissociated internal working models of self and the attachment figure. The individual states, "I don't know who I am," "I feel like an

imposter,” or “I’m really bad, but pretend to be good.” This is starkly exemplified by the priest who has been a “devoted servant of God,” but who molests children or has chronic affairs with church wives, or the family man who has routine homosexual liaisons or engages repetitively in “sexually addictive” forms of acting-out. Similar to the childhood experience of the mother who was both kind and mean, the person may perceive closeness with all potential partners as both necessary and distressing, which leads to monumental courtship ambivalence and numbing of experiences of affection.

Within the developmental model of affectional systems, critical capacities must be assimilated or symptoms may emerge. These include, affect regulation, social skills and perceived efficacy in attempting to negotiate social relationships, empathy and compassion for others, and capacity for accurate attunement regarding cues from others. These structural capacities make up the stage upon which psychological drama unfolds [30]. These are the targets of developmentally- based psychotherapies. Child abuse and neglect are the common factors in the histories of individuals who manifest hypo and hyper sexualities. It is critical to dissect the structural deficits which occur with abuse and neglect and utilize cognitive-affective-behavioral therapies for developmental repair.

At the core of one’s capacity to bond is self-empathy and the capacity for self-care. In the absence of an alternative validating caretakers, the individual does not internalize a caring relationship with self. A child who is rejected or abandoned tends to develop negative core schemas or beliefs about self. Accompanying modes of processing and organizing information (including affects) unfold such that these beliefs become self-perpetuating. These modes ultimately organize an individual’s range and type of interactions constraining possibilities for new learning with respect to intimacy. Such difficulties, have cause some to describe sex

offenders as “fixated,” that is structurally stuck at child and adolescent stages of development and fearful of adult relationships and burdens.

The self comes to exist in the context of others, within an aggregation of experiences of the self in relationship. Invariant aspects of the self and others in relationship are abstracted into what Bowlby called “internal representational models.” New experiences are then absorbed into earlier representations, creating and maintaining an individual who is distinct from others. The internal working models of sexual compulsives are filled with self hatred and the need to compensate by pretending to be powerful, effective, or competent. This imposter imbalance creates anxiety, and eventually the sexual behavior allows them the relief of being caught and punished.

The individual also creates self-functions, which are tools to negotiate interactions with others, manage the intensity of the experience, and balance inner and outer experiences. Self functions navigate the balance between their old and new experiences by means of moderating intense feelings. Examples of self functions include: social skills, appropriate affects with others, social anxiety, listening abilities, anger management problems solving, tolerance empathy – all which the sexual compulsives often experiences difficulties. Availability of self-efficacy determines behavioral manifestations of alternating degrees of closeness and distance. When the balance of closeness and distance is dysfunctional rather than adaptive, intimacy disorders emerge.

One type of intimacy disorder originates when the child experiences a disorganized attachment [31] [32]. The infant becomes highly sensitized to soothing the caretaker, presumably to exert control and self-protection. The cost of surviving is to give up the

development and differentiation of an autonomous self, which requires sufficient safety to individuate. The individual then attempts to create safety and consistency in maladaptive ways, (i.e. distorted survival strategies). In this intimacy dysfunction, an individual repeatedly finds individuals who need care, constructing an illusion of safety and control. They become an extension of their partner's identity and their boundaries become blurred such that it feels as if the other is vital to the self's survival. They simultaneously experience a need to merge like a child to a caretaker, and a need to run, for fear that they will be engulfed or abandoned. They also experience ambivalence related to the need to use others for self-soothing versus being independent. If sexuality has also been injured in its unfolding through association with violence or loss of control, ambivalence extends more profoundly into the closeness/distance continuum. This ambivalence can be played out in a myriad of destructive ways, ranging from repetitive affairs to low sexual drive.

Deficits in the first year of life typically lead to self-cohesion difficulties, leaving the individual vulnerable to fragmentation. Epstein has [33] suggested that the result of internal self-fragmentation is the creation, metaphorically speaking, of "black holes that absorb fear and create the defensive posture of the isolated self-unable to make satisfying contact with oneself or others". Without basic integration, the individual experiences one's identity as many "selves," or feels like an imposter due to inherent experience of contradiction. Each of these "selves" has the capacity to produce behavior, and has impulses for action. One system can be cut off from another, leading to unconscious motives for behavior. This fragmentation may explain why some individuals can find young children sexually arousing, (i.e. a part of self with a developmental age of 6-10 takes executive control but has the sexual arousal of an adult). Where there is extreme internal encapsulation, a person can act with seeming integrity (such as a

member of the clergy or the principle of a school), have multiple sexual partners, or molest a child, lie to others, and seem quite sincere, while actually not experiencing conflict or the implied contradiction. The mechanism of dissociation allows for the apparent anomaly in which “Good people do bad things.” This explanation of deviant sexual arousal patterns is consistent with the repeated findings of early neglect, abuse in the biography of sexual offenders [34]. In more extreme cases with early parental deprivation, sexual acting out can become more violent and act as revenge [35].

During the second and third years of life, self-constancy is established. The child develops tolerance for separation and the capacity for self-soothing. He or she begins to internalize the belief that of “being loved and valued,” and do not need constant reassurance. Children form a positive self-object [36], which allows them to experience a schema internally for being cared for in the absence of the caretaker. Children raised in state institutions in Romania and adopted in the U.S. may need to be told “I love you” by their caretaker a hundred times a day, because they do not have an internal structure to retain the belief [37]. In committed relationships, such individuals may desire sex constantly in order to feel desired or may need to seduce or flirt compulsively to feel desirable.

By four years of age, the child develops self-agency or the ability to operate in the world and actively create or elicit responses from others. The child develops a lexicon for affect and forms a framework for self-efficacy and mastery. The result of the healthy development of self cohesion, self constancy, and self agency is self-esteem. Positive affect becomes integrated with self representation.

Individuals with intimacy disorders may lack a positive self-object and require other's mirroring continually to maintain their sense of self. They become highly suggestible and susceptible to influence. They lack self-esteem, chronically, and become human "doing" rather than "being," since they experience themselves as being only as good as their last response. Men who have anonymous sex with multiple partners in a night may verbalize that they "feel only as good as their last trick." This is similar to individuals driven to make one business deal after another, at great cost to their family life, in order to attain more money, more status, or other illusions of safety.

The love map, which organizes the self-functions and facilitate relational choices, is structured by 5 or 6 years. Perceptions of what is attractive in oneself and one's potential partners are organized in the care of the love map. Persons with vandalized love maps maintain a "confirming bias" by selective interaction with others in the environment. They choose relations which fit the exiting core schemata and avoid or devalue relations which might refute central beliefs and affects of the schemata. In this manner, the intimacy disordered individual is held captive by the damaged love map until new learning can occur.

Affect Dysregulation

Abused children encounter substantial difficulty in accomplishing the developmental task of acquiring an effective strategy for regulation of their emotions within the relationship with caretakers [38], contributing to further social rejection. Learning to turn to people as a source of comfort is essential for metabolizing toxic negative emotions and fearing close relationships leaves individual's vulnerable to alternative solutions such as public exposure or fetishes. Some individuals however, seem to be "saved" by novel experiences with a loving caretaker, teacher,

friend, girlfriend or therapist. During the young adolescent years, there are rehearsals of courtship proceptive behavior [39] such as touching, kissing, holding hands and so on. Boys who fall behind with courtship develop social anxieties and fears which cause them to fall further behind. They often turn to pornography, which becomes a reservoir of deviant arousal conditioning at a critical period when they are flooded with testicular androgens. Girls may also visit sexual Internet sites or chat rooms, which likewise introduce opportunities for deviant experiences to the experientially vulnerable and naïve (see chapter by Martha Turner in this paper).

Stroufe [40] found that avoidantly attached boys were more likely to bully, lie, cheat, destroy things, brag, act cruelly, disrupt the class, swear, tease, threaten, argue, and throw temper tantrums; while girls were more likely to become depressed and blame themselves. Thus the same early deprivation leads to more acting out and aggression in boys, which is quite likely the reason boys are much more inclined to meld aggression with sexual behavior as a solution to affect dysregulation. Judith Herman (1990) observed that abused children develop maladaptive self-regulatory mechanisms:

“Abused children discover they can produce release through emotions becoming dysregulated and the child is unable to find a consistent strategy for establishing comfort and security under stress. Such individuals become more likely to exhibit self-destructive behavior – acting in or acting out”

These same individuals are also impaired in their capacity to reflect upon their own feelings and those of others [41]. They often seek chaotic relationships, recreating and reenacting the familiar early rejections and frustrations in new formats with peers in school [42], which likely is a way of dealing with autonomic dysregulation [43]. Purging, vomiting, compulsive sexual behavior, compulsive risk taking, gambling and exposure to alcohol and drugs

become vehicles with which abused children regulate their internal state. The abused and neglected child comes to anticipate abandonment, rejection, unfairness and conflict with caretakers and teachers, which then leads to powerful feelings of rage, anxiety and helplessness. Unable to establish safety in or out of the home, the individual survives by suppressing affect and then is compulsively driven to activity for release. Acting-out is often punished ostensibly for the “child’s own good” [44], further suppressing rage and activating the search for additional tension reducing activity. Tension reduction affords self soothing, anesthesia from pain and restoration of affective control, increasing the likelihood of repeating the behavior.

Suppression of affect seems to leak into somatic function [45] causing increased medical symptoms and also into somatic symptoms related to sexuality (more males) and eating (more females) behavior. The individual seems to interpret strong emotions as synonymous cognitively with a desire for compulsive acting-out, i.e., I’m lonely = I need sex; I’m frustrated = I need sex; I’m sad = I need a sexual partner. These releases are exacerbated by increased autonomic arousal [46]. The individual may feel sad, angry or lonely but, within the context of alexithymia, will experience the affect as hypersexuality – and turn, for example, to Internet sexuality for hours, cementing the connection and habit. In this manner, the individual discovers that this behavior can be self-soothing; it becomes a habit and eventually part of their identity – i.e. I am an ‘exhibitionist,’ a ‘pervert’ and so on. The relationship with an object makes them feel more like an object even as it further insulates them from anticipated or actual rejection from other people.

Trauma Reenactments

In the dissociative daze of childhood sexual abuse, children seek to repeat elements of a traumatic event or unresolved ambivalent attachment, i.e. they do to others what was done to them [47]. Often they identify with the aggressor and display assaultive behavior or turn the anger inward and develop self-destructive strategies.

Horowitz (1986), having studied adaptations to severe stressors in childhood, has suggested that the common “natural” result of severe trauma is repetition, which consists of flashbacks, intrusions and reenactment, until there is completion. If the stress response cycle is not successfully completed, erroneous schema become engraved into the internal working model of self. Relationships created by unresolved individuals are likely to reenact by means of disguised repetitions, with accompanying numbing and intrusions, throughout their lives [48]. Dissociative defenses resulting from both trauma and disorganized attachment interfere with completion and mastery and/or “working through” the trauma. The result is that many victims of childhood abuse experience memory disturbances [49] and are left to repeat the trauma in disguised form unaware of its origin. Compulsive reenactment often includes “acting-in” compulsions such as self-cutting or eating disorder, or “acting-out” compulsions such as hypersexual acting-out or destructive relationship reenactments such as picking alcoholic partners repeatedly or battering relationships. These reenactments can become addictive, serving as distractions from the internal emptiness and constriction and giving the individual the illusion of temporary connectedness, power and control, as well as relief from loneliness and depression. This reliance is further potentiated by endorphin release [50] [51], extreme alterations in cortisol regulation and dopamine release from the median eminence.

Serendipitously, the study of sexual abuse victims has resulted in a new understanding of paraphilia and sexual compulsive behavior. Men and women who are sexually abused will

frequently present clinically with violent paraphiliac sexual arousal and imagery, which is the result of “trauma-bonding” [52]. In trauma-bonding, there is a pairing of sexual arousal with terror and violence at a critical stage in the child’s development. Thereafter, there is a tendency to revisit the terror and high arousal, as if to master, complete or comprehend it. Clinically, traumatized children tend to repeat violence in their play rehearsals, and molested children often act out the molestation in their doll play. This is an example from one sexually abused client:

“After dad awakened the sexual awareness, I couldn’t understand it. As I got older, it became more and more of a problem for me. I couldn’t turn to you, you would blame me. So I turned to boys who would duplicate some of those feelings – of being cared for or loved. I knew I was fooling myself. I felt the emptiness I was left with after my liaisons with boys, but it was all I had. I was desperate to feel loved. I needed affection, even if it was pretend affection. My need for affection was so strong, I couldn’t say no to many people. Even though it left me feeling miserable.”

Adults traumatized as children appear as though frozen at the point of trauma, acting-out the violence over and over in their self-destructive decisions. Sexually abused women will often self-mutilate, a compulsive-ritualized self-destructive act, and describe their response as “an intensely pleasurable release” that helps them feel alive. Psychologically, there is an analgesic effect associated with the cutting and quite likely an opioid endorphin release centrally, which the individual experiences as pleasurable [53]. Cognitively, there is dissociation and depersonalization. Dissociation here implies a numbing-out, a disconnection of thoughts and feelings. During the trauma, an individual may feel as if she is leaving the body and becoming part of the wall or ceiling, which is a functional defense against the intolerable feelings of being in a body which is under assault. Thereafter, dissociation may serve as an automatic defense. Depersonalization in this context reflects that the individual has been treated like an object, thereafter feels like an object, and objectifies others. Because of the trauma bond, abuse survivors repetitively re-victimize themselves and can seem to invite chaos and crisis, in some

cases not just out of familiarity and expectation but also, paradoxically as a means of mastering the trauma. Masochistically, the emotional and physical pain may “feel good,” as well as providing an escape from the numbness and emptiness resulting from the dissociation and depersonalization.

Dissociation in males seems somewhat different than in females. Research on the effects of post-traumatic stress on monkeys suggests that similar stress has gender-specific effects, with males more dramatically manifesting the impact. Male monkeys tend to act-out more, while females typically act-in. The adult male deprived of parenting in childhood will often attack other monkeys viciously- acting out of fear, hyper-responsivity and consequent anger [54]. The female, also hyper-reactive, bites herself and develops catatonic symptoms.

Human females who have been victims of neglect and sexual and/or physical abuse often report that they do not feel entitled to express their pain and fear retribution if they show strong emotion. When in close proximity to a male, particularly in a potentially intimate interchange, they dissociate. During any kind of sexual contact, they “numb-out,” not thinking or feeling but instead locked in terror, feeling unentitled to say no. On the biofeedback machine, discussion of a sexual encounter is often associated with levels of anxiety sufficient to precipitate a panic attack. A common sexually compulsive posture on the part of some women in response to the terror is to allow a “seductive” part of their personality to “take control” of the situation. They then maintain the illusion that they are in control of their sexual victimization “this time.”

Human males, on the other hand, are often unaware of their effective states, being so dissociated that they never register fear, anger, anxiety, or any emotion other than irritability. Thus, when they approach a fearful situation, they bypass all affect and their ritualized behavior patterns become the sole automatic response to fear-related situations. Men typically oscillate between

over-controlled working , drinking, eating or sex, to being out-of -control in order to avoid encountering or remembering situations that are terrifying. The masculine counterpart in acting-in behavior consists of rigid rules, rituals to bind the anxiety and quell the fear of which they remain afraid at an unconscious level.

Frederich (1992) [55] asked mothers of 882 children who were not sexually abused and 276 mothers of children who were sexually molested to indicate the sexual behaviors shown by their children. Twenty- five behaviors were more prevalent in the sexually abused children. A high frequency of sexual behavior was related to more severe abuse, a greater number of perpetrators and the use of force. Similarly, among 1000 women presenting to our sexual trauma program, one out of five reported sexually abusing, most commonly while babysitting, as an adolescent. The following is a description written by one client:

“There was a time at age 10 (right before I almost got beat to death and put into a foster home) that I was babysitting while my parents were out of town. I felt so lonely and scared. I had an empty funny feeling inside I had to fill – I didn’t know what it was. I found myself in the room where my younger brother was asleep. He evidently was sleeping nude because I really don’t remember taking his unders down. I touched him down there so we could “fill each other.” I felt sick as I started doing this but kept on a couple of seconds more. He was asleep and looked so innocent that I really felt disgusted and I stopped. I got really sick and ran crying because I was so ashamed. I wonder if he remembers it. I’m sure he does.

I did the same thing one time with my younger sister. My older sister had taught me how to masturbate when I was five so men wouldn’t touch me. I was changing my younger sister’s panties and when I pulled them up I guess I was “triggered” into wanting to “break” her in (so she wouldn’t hurt?? Or to get her used to it? Or maybe I even wondered what my older sister had gotten out of touching me?) I touched her and realized I didn’t like what I was doing. I felt sick in my stomach – guilty – ashamed, and sorry for what I had attempted to do – or had started to do. I never even thought these things again – ever – with any children.

One day (at age 21?) ...my mother lived across the street from me. She would ask my husband if I could go drinking with her so I could drive home and it was okay with him.

I was over at her house. I always had a “need” to be close to mommy and hoped there would be that one day she would hold and comfort me – and tell me she was so sorry for what happened to me. That day she said, “Let’s go lie down.” I said, “OK!” (I remember thinking – I was going to take a nap with *my mommie!*)

We were lying down. I had my clothes on. She was lying there with her eyes shut. I glanced down and saw she wasn’t covered. She was either undressed or dressed very seductively. Her leg moved out a little (while she was sleeping?).

All of a sudden I felt anger, a rage, and an overwhelming feeling I can’t describe. I wanted to molest my mother. I wanted to do to her what had been done to me by my father and stepfather. She had allowed it to happen – she knew about it all along. I wanted to rape her. I reached over and put my hand on her crotch and started to put my finger in her. She squirmed with a moan of desire and I snapped into reality. I was overwhelmed with feelings of sickness in my stomach. I felt both shame and guilt – I don’t know. I got sick and went home. It has never been mentioned again.”

For individuals such as these, victim becoming victimizer can present more as a dissociative-like repetition of what was done to them, rather than paraphiliac sexual arousal. For some, this behavior eventually becomes part of deviant sexual arousal patterns.

A member of the clergy, professing celibacy and chastity, spends hours on the Internet cruising pornography websites and masturbating while “cybering” with a teenage boy. He is a survivor of childhood sexual abuse, who is unaware of how he is re-enacting the trauma in this distorted attempt to reclaim lost youth. A woman who had a pregnancy out of wedlock gave up her infant for adoption when she was 16 years old. At 35 years old, after having another child, she becomes addicted to cybersex contacts in which she is treated badly like a “dirty slut.” Her behavior reveals the unfinished contradiction in her life: “I may look normal and good, but secretly I’m bad and sexuality is the source of my badness.”

Heterosexual men who had repetitive preadolescent sexual contacts with a male may become involved in same sex chat and masturbation on the Internet as a means of re-enacting the question, “Am I gay?” For some married persons, cybersex is an ideal mechanism for revenge or

“payback.” Compulsive cybersex users explained to their spouses when detected, “Somebody out there wants me if you don’t” and “You spend too much money on what you want, I’m entitled to have my way.” Some of the examples are so paradoxical they are easily viewed as perverse. A attorney in the midst of prosecuting sex offenders sits in his office and repeatedly masturbates while using his work computer. The father of three adolescent girls, who he encourages to “Just say no” to sex, retires to his study and solicits in a chat room a teenage for a sexual liaison. The Dr. Jeckyl and Mr. Hyde quality of these transactions reflect the strength of dissociation in disconnecting parts of the self.

The survival strategy of dissociation evolved in childhood to manage disparate experiences such as tolerating physical abuse at home, while maintaining capacities for socializing and learning at school. Dissociation, through the mechanism of encapsulation, helps an individual forget overwhelming childhood experiences, which are fragmented and stored in various parts of memory. However, these dissociated experiences eventually leak into consciousness as re-enactments. The woman who is unable to refuse any sexual advance and responds repeatedly to solicitations on the Internet cannot remember the incest from her childhood. Paradoxically, the compulsive re-enactment will not let her forget the abuse that is now repeated almost daily through the computer usage. In compulsive sexual behavior, it is likely that an ego state has evolved to re-enact unfinished business, while the executive self parents, goes to work, or otherwise maintains a normal lifestyle [56].

Compulsive sexual behavior can also function as a distraction from the burdensome consequences of selfhood, such as shame and perfectionism. Any tension reducing event, such as bingeing or purging in bulimia, self-cutting, or compulsively masturbating to orgasm serves the function of narrowing the perceptual field to concrete events and refocusing the attention

away from distressing cognition and affect. Masturbation during cybersex suppresses awareness and expression of emotion.

The body symbolizes the playing field for working through unsolvable life problems. One cybersex addict embraced the numbing, depersonalizing quality of his compulsive sexual behavior. He had sex with his brother's wife over twenty years ago. His brother was killed in an accident two days after the affair. During therapy, he wondered if his brother committed suicide or, in a childlike ego state he imagined he caused his brother's death. He took his brother's place by being immersed in affairs and becoming dead to the world. His compulsive sexual behavior ultimately became his dissociative effort at reconciling the unreconcilable: "My shameful out-of-control sex killed my brother" and "I can't tell anyone, but my illicit behavior will eventually cause me to get the punishment I deserve."

Compulsive sexual behavior can become a primary or exclusive means of sexual outlet in which the survivor of childhood trauma encapsulates the overwhelming pain and shame of the past, re-enacts salient features of the original events, and copes with the increasingly burdensome demands of selfhood in daily life. Individuals lead conflictual, fragmented lives in which there are many paradoxes. They attempt to escape from pain by harming themselves or others. They want to be wanted, but hide their identities behind false identities and ritualized role play. They seek closeness with detached persons who may be thousands of miles away. They seek intense immediate experiences through a medium that will insure depersonalization and objectification.

Eventually compulsive sexual behavior participants experience the "bottoming out" process in which powerlessness and unmanageability confront the illusions of the addictive

lifestyle. They can become involved in a recovery process truly dedicated to finding lost parts of oneself by abstaining from compulsive re-enactments and reconstructing the vulnerable self.

Turning to Others for Comfort and Support

Jeffery Young (2007) has suggested that people develop internal working models based upon the schema summarized in Table I. Schema are: a broad pervasive theme comprised of memories, bodily sensations, emotions and cognitions regarding oneself and one's relationships with others developed during childhood and adolescence and elaborated throughout one's life.

If an individual does not trust others because of attachment trauma and they have the contradictory biological drive to mate and be sexual, paraphilia solves the problem by allowing the individual to have sex while distancing himself or herself with imagery. Masters and Johnson studied sexual arousal patterns of a nonclinical sample and discovered the most common sexual fantasies of both men and women were (1) sex with strangers and (2) sex with anonymous, faceless partners. Sexual arousal patterns reflect the style of closeness and distance the schema allow. As individuals tolerate greater intimacy, the sexual arousal patterns commonly change. Since changing arousal and fantasy patterns is necessary for comprehensive treatment, changing the schema for trust, and safety is essential. In our experience, this begins with client beginning to trust themselves. One client stated, "I am a liar, cheat, and thief, so I have to assume you are like me." To trust himself, he had to establish greater integrity and not act on self-destructive "dark-side" impulses, which then allowed him to trust others. Sexually out-of-control behavior results in chronic lies to keep the "secrets" which is the germ of self-hatred. Doing what Samenow [57] defines as "opening the channel" and behaving for a period without lying, allows the seed for self-empathy to grow.

Paraphilia

The terminology for problematic sexual behavior remains confusing. Different terminology is useful, however, in describing a common symptom that derives from a common developmental trajectory. It suggests that clients with the same symptom can actually be more different than they are similar, and can therefore require greatly different interventions.

Paraphilia is the most precise term for a variety of out-of-control sexual behaviors. Para means “besides,” and philia “love,” so the term rightly implies a disorder of love, which is experienced as distressing. It suggests that an individual is aroused by atypical sexual imagery or the existence of a sexual object that “intrudes upon or displaces” more common arousal patterns, such as an attractive age mate for which one could hypothetically develop affection. An individual with a leather fetish for example, finds that leather becomes both necessary and distressing, in that it is requisite for sexual arousal while a desirable partner alone insufficient. Other critical components of paraphilias typically include an element of illicitness [58]; the individual requires secretive behavior such as paying for rooms in “porn-houses” in which strangers perform sexual acts or engaging in anonymous sex acts in public restrooms, as described in Humphreys treatise on the “Tea Room Trade” [59]. In this manner, the possibility of “being caught” is at once alluring and at the same time as provides “evidence” of deserving punishment for being “bad” – often mirroring destructive childhood sexual development where pleasurable sexual feelings were over-paired with guilt, stigma, or punishment [60].

Homosexual “tricking,” for example involves multiple sequential partners and is energized both by the illicitness and the excitement of “someone” desiring or wanting them. It is a peculiar feature of such acts, that the individuals are often so numb or dissociated that the

partners chosen are neither attractive or even sexually arousing to them, rather it is the “being desired” that is critical. In extreme cases of this behavior within the gay community, the “trick” may even have open HIV sores but sex still takes place, as if the individual is playing Russian Roulette with life and death.

Most recently, under the heading of paraphilia, individuals report preoccupation with Internet pornography. This behavior is less “intrusive” in the obsessive-imagery sense, but still problematic in that it displaces activity with a partner, most commonly their spouse. If such activity involves illegal behavior, the term sex offender is used. Some individuals report comorbid depressive and anxiety symptoms that are temporarily ameliorated by the behavior, thus the symptom becomes entrenched as a form of affect-regulation. Such cases remind the clinician of alcohol or drug addiction in that more and more activity is needed to satisfy, similar to feelings of withdrawal and tolerance. The individual often escapes into a pleasurable activity temporarily, but then recognizes that the behavior absorbs increasing dimensions of their life, threatening relationships and employment and generating hatred. Serotonin reuptake inhibitors can often control such behavior (see chapter by Codispodi in this book).

In select cases, the activity looks more like an obsessive-compulsive-spectrum disorder characterized by repetitive, driven behaviors that lie along an axis with compulsivity (risk avoidance) and impulsivity (risk and pleasure seeking). The difference between the spectrum disorders lies in the motivation for the repetitive behavior. Disorders at the compulsive end of the spectrum are motivated by harm avoidance and a desire to decrease anxiety. Those at the impulsive end are motivated by impulsiveness and a desire to maximize pleasure [61]. The key feature in the labeling of obsessive- compulsive spectrum is that medications such as

monoxidase inhibitors can produce almost immediate cessation of the activity, similar to their effect on a hand washing compulsion.

With paraphilic activity some clients avoid intimacy because loved ones (the parents) were often sources of danger. Close relationships were necessary but distressing -- and still are. For others sexual acting-out is a selfish pursuit of using others, hurting the people they purport to love most, as well as those they are attracted to. Essentially this manifestation of intimacy is a form of “moving against.” (Karen Horney) Stoller termed such behavior “perversion,” indicating the motive was rage and hostility. Such rage is the result of early attachment deficits and childhood abuse and neglect. In such cases, trauma-based psychotherapies are most effective in neutralizing rage and shame.

The point of this discussion is that, similar to eating disorders, symptoms such as hypersexual behavior are a complex manifestation of many divergent pathways, the common features being: (1) intrusive imagery, (2) displacing partner bonding, (3) a pattern of moving towards, away or against in bonding, (4) development of the symptom as a form of affect regulation, (5) using the symptom to relieve or combat anxiety and/or depressive disorder (6) the symptom becomes addictive,- characterized by tolerance, withdrawal, habit formation, and interference with work, family life, partner choice and intimacy, and (7) whether the behavior is illegal.

Vandalized Love Map

The unique aspect of sexuality in comparison to other natural functions is the cementing of arousal patterns and fantasy during adolescence. John Money (1986) [62] defined these arousal patterns more broadly as “lovemaps”:

“A personalized developmental representation or template in the mind or in the brain that depicts the idealized lover and the idealized program of sexueroetic activity with the lover as projected in imagery and idealization or actually engaged in with that lover”

Money pioneered the study of structural and developmental contributions to the affectional systems. Like Bowlby, Money believed that actual biographical events related to attachment and trauma influence the development of a love map that can become “vandalized.” Too much punishment associated with genital sexuality or out-of-control premature sexualization in the household constitute two examples. The developing love map encompasses proceptive events such as the range of partner characteristics which sexually arouse of the body to respond to touch or genitals to respond to various stimuli, and the sense of self as attractive, which obviously influences the perception of others as pleasurable. Some theorists assert that deviation in the development of proceptive love maps become “delayed,” “fixated” or “regressed,” while others suggest that deviant development continues, but along a different, distinct, or complex route [63]. The love map of the child molester has been labeled “fixated” [64] by some theorists and viewed as requiring unblocking or alternatively, it may have differentiated along a distinct pathway. Within a developmental psychopathology frame, such deviation can only be understood by looking at normal development, i.e. secure attachment modulated impulse control, adaptive temperament, entry into peer group and dating. Pathology reflects repeated failure of adaptation with respect to these issues. Change or resilience is also possible at many points. Puberty activates the “love map” established throughout childhood. Abel, Mittelman and Becker [65] evaluated 411 adult sex offenders in an outpatient clinic. Of this sample, 58% reported their deviant sexual arousal began prior to age 18. Other studies of juvenile offenders found that age of onset ranged from 13 to 15 years [66] Becker et al, (1986), including a wide variety of

paraphilias, among them molestation, voyeurism, exhibitionism, obscene phone calls, and transvestism beginning as early as 10 years of age.

Psychodynamics

Stoller (1975) [67] conceived of sexually compulsive behavior as “perversion,” that is “the erotic form of hatred that serves the function of revenge.” He states that the perversion serves a survival role by converting childhood trauma to triumph. The person seeks sexual release without genuinely caring about the sexual partner and with little empathetic connection to self or other. The goal is to fulfill an appetite regardless of other. Sometimes pleasure is even derived from degrading the other or self. In such cases, suppressed affect now is misdirected at oneself, one’s body, one’s genitals, one’s gender and/or one’s partner.

The “triumph over tragedy” is the result of repetition with the erotic theme of control. In this way, sexually acting-out is much like another form of being in charge of one’s pain, self-cutting, a reasonable adaptation to the double-bind polarizations of needing caretaking but fearing dependency, needing sexual release while being terrified of closeness and so-on. It allows for intimacy without connection as a survival solution to feared annihilation. For example, one client discussed a shameful sexual liaison that resulted in his being urinated on consensually. The feelings of degradation were re-experienced under hypnosis and then used to bridge him back to an age-regressed state. He began to relive an incident that occurred when he was a child and the school bully beat him up and urinated on him. At around the same age, he was used by his older brother as a sexual outlet, and peers were teasing him in other cruel ways. His brother confirmed the memories. By working with the intense affect and reliving the shame of the encounter, the client’s sexual arousal for urophilia diminished. Most cases of sexually

compulsive ego-states begin in adolescence [68] and often it is this adolescent self that holds the deviant arousal. From a developmental perspective, if bonding and sexuality are introduced to a child with contradictory affect, cognition and behavior, it is likely to remain intertwined in the “hard drive” of the brain.

Sexualized Children

Two changes are occurring in contemporary families. One is the increasing overindulgence of children by buying them products to compensate for parental neglect and absences. Frequently, the over-indulgences are accompanied by over-control in which the parent is also enmeshed with the child and has highly perfectionistic performance concerns for achievement. It is as if the child is “fed but not nourished.” Such families are often chaotic and the attachments are also disorganized. The cost of surviving in such families is often to give up the development of an autonomous self and rarely does their self-sufficient parenting allow natural maturation. The person is needy and develops strong dependency in relationships, wanting to merge, while simultaneously feeling it imperative to run away out of fear of rejection and loss of control. Such individuals have a poor sense of self or identity. They continually seek attachments to finish the self -- two halves making a whole -- but the relationships are conflicted. Sexuality seems premature in such relationships and can be experienced as traumatic since the individual is immature for her or his age. It is not uncommon in the treatment of the exhibitionist or voyeur to find that their primary relationship even in childhood is with their mother and they still live at home – they feel like this relationship is necessary but distressing.

The second change is the premature sexualization of children by exposure to eroticism by family, media, and role expectations. Children are also reaching puberty earlier and John Fowles

writes that, “It is as if a ship is sent to sea without a rudder.” Kids are genitally and socially eroticized without sufficient guidance and launching for attachments, i.e. “love education.” The result is that children can be exposed to sexuality and look okay on the outside but be traumatized internally by premature sexual and love experiences.

In such cases, the vulnerable child may be genitally activated but make poor decisions that will change their lives. They may sell themselves for ‘tricks’ in the homosexual community, seek out contact with neighborhood pedophiles, molest siblings or peers, flirt on the internet and so on.

Such individuals often confuse the need for affection with sexual arousal. This tendency is exacerbated by the media’s frequent and sensationalized use of sexuality to get the attention of children and adolescents without the ameliorating influence of parental guidance. Sibling or peer group pressure further encourages a “sexualized child,” who is experimenting with sexual behaviors before they are emotionally ready.

Addictive Cycles

Early attachment disorganization is experienced by the adult as numbness, constriction, feeling object-like, mechanical and empty – all of which propel the individual to seek relief, escape and connection. Such individuals were labeled “bypassers” by Masters and Johnson (1972) [69] because they became sexually aroused reflexively without much attraction or affection for their partners. Typically, such individuals feel internal polarities of dependency; needs that feel insatiable because of childhood neglect and are often, experienced as terrifying. They exert “control” which results in periods of hyposexuality due to a fear of intimacy. Eventually the natural desire to escape their loneliness and bond, takes over and they enter a

release phase of being out-of-control and hypersexual. It is quite common to see such individuals cycle, much like the anorexic-binge type, from what appears as “sexual anorexia” to sexual out-of-control (bingeing) – over-control/out-of-control cycles. In some ways sex is objectifying and depersonalizing and therefore non-intimate so, often after the release of orgasm, emptiness quickly follows, requiring another “hit.” This can appear “addictive” in that the individual quickly cycles from the high -- some illusion of connection or escape from emptiness – to the deep loss of profound aloneness.

This pattern is most common within the gay community - in anonymous sex scenes or bath houses in which the individual will “fuck” multiple times in an evening; however it has become increasingly common with cybersex addictions in which individuals masturbate to their computer screens. Of a large sample [70] 96% of males and females reported feeling addicted to Internet sex and spent more than ___ hours a week on sexual online activity. In 1999, there were 19,542,710 unique visitors a month on the top five pay pornography sites, 70% of that number visiting on weekdays between 9:00am-5:00pm. Today, approximately 40 million Americans admit to regularly visiting pornography websites.

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Table .1

Child	Adult
Secure <ul style="list-style-type: none">• Seeks comfort• Caregiver is a secure base relieved (upon return of mom), seek comfort, feel comforted, resume play. Relax completely in mother's arms, allow full embrace, back to play.	Secure <ul style="list-style-type: none">• Coherence• Consistency• Collaboration
Avoidant <ul style="list-style-type: none">• Minimizes distress; avoids contact• It is as if the mother has not re-entered the room...Stroufe showed elevated heart rate which does not decline with Mom's return	Dismissing <ul style="list-style-type: none">• Idealization with discrepancies• Insistence on inability to recall childhood• Derogating dismissal (Rarely: Fear of loss of child through death)
Resistant/Ambivalent <ul style="list-style-type: none">• Heightens distress – ambivalent• Seek contact, but whiney, resistant, ambivalent to contact (approach/avoidance)	Preoccupied <ul style="list-style-type: none">• Involving preoccupying anger• Passivity/Vagueness in discourse
Disorganized <ul style="list-style-type: none">• Contradictory behaviors	Unresolved/Disorganized <ul style="list-style-type: none">• States of mind with respect to:• Experiences of loss• Responses to abuse