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Sexual Behavior and Therapy after Childhood Sexual Trauma

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Abstract

Treatment of sexual desire and arousal difficulties after a childhood history of sexual trauma is complex. Adding to this complexity is the lack of a comprehensive description of proven treatment components. This article summarizes components of successful treatment based on concepts and protocols formed across 40 years of clinical experience, as well as a review of existing clinical research.

INTRODUCTION

The landscape for therapists treating sexual disorders is quite different now than just a few decades ago and remains poorly mapped. Oversights occurred on both ends of the sexual desire spectrum resulted in little being known about both hyposexuality and hypersexuality post-trauma. From the sex therapist's perspective, Masters and Johnson [1], failed to recognize the vast numbers of clients with inhibited sexual desire [2]. At the other end, Kaplan [3], said, "In my experience, excessive sexual desire is so rare as to constitute a clinical curiosity when it's a primary symptom." A majority of texts on trauma and PTSD have shown a near total absence of chapters on treating sexual disorders (with notable exceptions [Courtois, 2005]) [4], despite the fact that the sexuality of most people is almost certainly affected by incest, rape, or stigmatized sexual encounters. Two comprehensive reviews on the sexual sequelae of child sexual abuse on desire and arousal in women document a risk for adult sexual desire difficulties [5]. Even within the subspecialty of sex therapy, many are unaware of the clinical wisdom related to dissociative features of sexual behavior. Chefetz [6], most articulately supports the relevance of dissociative theory:

"The absence of a clear and coherent sense of being present in a body and experiencing the sensations associated with sexual activity, including the sensual ones, is an indication of the dissociative isolation of somatic experience from awareness. The human need to hold and be held is missing in action when there is isolation of somatic experience from awareness. Or, as one of his patients is quoted, 'I am a million miles away, but he never notices.'"

Even the best somatic-based texts related to trauma [7], do not adequately document the most common manifestations of rape trauma during sexual interactions. The other under-discussed phenomenon is the ubiquitous concept of revictimization: when a person reenacts the event and puts him or herself in situations where aspects of the event are likely to happen again. Victims of rape are more likely to be raped again. Victims of child sexual abuse are at greater risk of becoming prostitutes [8], or posing for pornography.

In our clinical experience, victimized children often re-enact behaviors and will sometimes touch other children sexually and have recurring body memories on a somatic level. Adult clients use pornography or create imagery during sex of violent acts to become aroused or orgasmic, which often feels confusing and revictimizing. They create traumatic bonds and recreate violent interchanges in and out of the bedroom, replaying the trauma in disguised form. In an unconscious masochistic way, fear and pain seem to be intertwined with pleasure.

THE TRAUMA - SEXUALITY CONNECTION

The roots of such sadomasochistic images and behavior lie in internal working models of disorganized attachment (discussed in text), where affection and terror become wired together. As Dan Siegel states [9], "Neurons that fire together wire together!" This wiring may also be biochemical; the dysregulation of the cortisol system is the hallmark of PTSD [10], and sexual arousal is accompanied by significant cortisol changes. Women who show an increase in cortisol to an erotic film, rather than the expected decrease, report lower sexual satisfaction [11]. The result might be that passionate arousal in sex depends on violence even at a biochemical level.

The first stage in recovering sexual function requires breaking the dissociative barriers related to isolation, disconnection and affect suppression so that the part of self that was sacrificed to gain safety can be reclaimed and embodied. Chefetz again elegantly reflects this,

"We repeat because the dissociative process maintains the isolation of elements of experience often riddled with shame, terror, hatred, helplessness, and all the other miseries of human tragedy."

In other words, sexual enactments can hold dissociated parts of the patient's self and relational history. The symptoms have lost connection to the events that catalyzed their onset and take on a life of their own. Therapy consists of finding and connecting parts of the individual self that have long been disconnected [12].

Sexual re-scripting is a required component of recovery, allowing for the creation of a new template in the brain for affectional interchange. The hardwiring of fear and pain with pleasure requires changing habits strongly cemented by operant and classical conditioning, often relating to masturbation and pornography.

DISSOCIATION, DISORGANIZED ATTACHMENT AND SEXUALITY

A 30-year longitudinal study by Sroufe and colleagues [13], demonstrated that individuals with a history of disorganized attachment in infancy are more likely to have dissociative disorder in adulthood. With disorganized attachment, the parent who is depended on as a source of safety in the first few years of life is also the source of danger, causing fragmentation of the child's self-system, i.e. "I am bad, they are good." The result can be a hatred of self (shame) and anger at both self and others, amplifying self-injury and fear. The sexual arousal patterns are thereby wired with contradictions; the schema of safety, trust and intimacy are wired to fear and betrayal, and pain with pleasure. Parts of self become polarized and the individual receives internal messages that are contradictions. The following clinical vignette illustrates this internal confusion.

TRAUMA BONDING AND SEXUALITY

When sexual unfolding occurs prematurely and in a context of force, coercion, brutality and objectification, elements become intertwined that under healthy, developmentally natural circumstances, would not. The most damaging fusion of elements may be the pairing of terror with sexual arousal. One dissociative client described how she experiences this phenomenon relative to her sexual response. Fear had become hardwired to sexual sensations because of repeated incest.

"I don't know that we've ever experienced true sexual arousal -- only fear arousal driven by terror, anxiety or excitement that is basically over-stimulation. When we feel these, it translates into a physical response in the vagina area. If, for example, we go to the store and there are too many colors, too many shapes, we feel sexual feelings."

It is important to keep in mind a child's limitations in processing and coding these overwhelming, sensory-affective experiences, i.e. primary-process thinking. When an adult sexually abuses a young child, the child does not always perceive what is happening as sexual. The child sees threatening movement, objects and shapes coming too fast, feels overwhelming stimulation, too much too fast to process. He or she is flooded, immobilized, panicked and psychologically catapulted beyond any known frames of reference. The child has no basis for understanding these actions, can't breathe; the body is crushed under adult weight; orifices are violated; he or she thinks they will die.

Amidst all this annihilating havoc, sexual arousal is born, classically and operantly conditioned, paired now and ever after with images of violence and feelings of violation, humiliation, unbounded terror and fear of death. In the future, when the child feels scared, he or she will feel aroused. Many scary things are likely in the environment of a child being chronically, sexually abused. In response, he may begin to touch himself or move in ways that temporarily resolve the genital sensory overload that seems to occur out of nowhere. The child does not know she is a compulsive masturbator -- she simply seeks relief from overwhelming sensations. If in response, the child is punished or humiliated, or the perpetrator uses these actions to convince the child that he or she "wants" more abuse, the damage is compounded exponentially.

One "solution" to this irreconcilable conflict and shame is that the dissociative child may split, and a part of self encapsulates the belief system or cognitive distortions propagated by the perpetrator. This part of self may claim to "like" the abuse, welcome it, view his or her own existence as centered around performing sexually and claim to view the perpetrator as an ally or "my only friend." This adaptation is not uncommon when the sexual abuse is escalating at the hands of a particularly brutal father or father figure in the context of little available nurturing by other caregivers. It permits the child to not have to relinquish a beloved and needed love object: the father. The cost, however, is a part of self that continues to enact its role over and over (often into adulthood), even after the abuse that originated it has ceased. In so doing, the self-attributions of badness become increasingly entrenched, and the individual is drawn to circumstances likely to culminate in revictimization after revictimization.

DISORDERS OF INTIMACY

The basic philosophy of treatment is that sexual problems are a subset of intimacy disorders and require the "integration" of disorganized, contradictory and dissociated systems; what Mary Main at Berkeley has described as "earned-secure" attachment [14]. "Earned-secure" attachment refers to a creating a "fresh" look at one's past and a metacognitive shift to make meaning of recollections (Table 1).

Also critical to recovery is formally breaking the trauma bond. The therapist identifies the dissociative parts of self involved in destructive choices of reenactment and enables the client to attach the contradictory cognition and affect they are experiencing to the actual childhood events that contributed to their origin. For example, a former client recalled that each time he has multiple "anonymous homosexual tricks" with strangers that interfere with his marriage and fatherhood, he gets somaticized butterflies in his stomach." In therapy, he recreates these feelings as he recounts a recent "sexual trick." He remembers the butterflies began when his father first molested him, an experience now made even more noxious since he recently discovered that his father was now molesting his own grandson, the client's son. This process brought the unconscious into conscious awareness, interfering with reenactment -- what Adler would call "spitting in the soup" – and thereby offering an opportunity to integrate the dissociated experience into the evolving, coherent, "fresh" sense of self.

When trauma is severe or occurs at a young age, the dissociated

Table 1: Components of Earned-Secure Attachment
1. Facilitating a coherent and reflective narrative.
2. Neutralizing idealization and loyalties to family system
3. Facilitating metacognition
4. Facilitating self-compassion
5. Utilizing an attuned relationship with therapist as a home base for exploration of developmental change
6. Asking others to do self-soothing under stress
7. Re-examine detailed beliefs about self and others.
8. Relinquishing defense of dissociation and re-associating affect, sensation, and knowledge
9. Not inhibit or minimize internal experiences and learn to tolerate, express attachment and related emotions
10. Resolution of internal relational exchanges between parts of self
11. Internalize self-parenting, is forgiving of mistakes, listens to disowned parts of self
12. Sets and teaches healthy boundaries
13. Resolution of significant losses in one's life
14. Deconstruct the attachment pattern of the past construct new ones
15. Integrate traumatic attachments, losses, and re-enactments
16. Establishing appropriate entitlements related to having needs, expressing needs, and meeting needs.

parts of self can be fragmented so that one part constantly feels vulnerable, as if it could be raped at any time. The difference between "then and now" is blurred. Such compartmentalization may have once allowed the individual to survive (i.e. don't think or feel, pretend it's not happening) but now the dissociated affect or cognition is activated even by a safe partner. Since parts of self may have limited information due to amnesia and dissociated awareness, they often create diversions by making the body big (binge eating), having obsessions such as distractions of counting (obsessive-compulsive), or behaving compulsively (eating disorders, sexual addiction), which substitute for real bonding.

The most common dissociative presentation following sexual abuse in our experience has been described by Steele and Van der Hart [15], as "structural dissociation," in which one part is protective and avoidant, and the other is needy, dependent or seductive, trying to get the love they desperately need and have not received. This is the essence of disorganized attachment. Often in these cases, the individual is hypersexual while dating and hyposexual after marriage. The intervention requires parts-oriented therapies such as Internal Family Systems[16], Gestalt ego-state, or psychodrama in which the goal is internal dialogue and allowing implicit memory to become explicit.

PREREQUISITES FOR HEALTHY SEXUALITY VS. TRAUMA LEARNING

To feel intimate with another individual, one must feel a sense of safety and connection. Simply lying naked next to another person involves a tremendous degree of vulnerability. Ideally we should feel that our being, both physical and emotional, will be respected. To safely transcend the physical boundaries that separate two bodies, we must initially feel a sense of, and a right to bodily and emotional integrity. We must feel entitled to have feelings and sensations, to say yes, to say no, to set limits, to protect self from harm and to move to enhance comfort and pleasure.

For an individual whose sexuality unfolded in the context of violation, these are foreign concepts. Sensation has been annihilating, feelings suppressed, comfort and pleasure an illusion Being close quickly escalating to feeling danger when seen or cared. The right to say no is unknown. Sexual connection has not been about two individuals of equal power and capacity entering into an experience by mutual agreement. Sexuality has consisted of subjugation and submission, with any early attempts at struggle giving way to a robot-like endurance during acts of violation and devastation.

Teaching healthy sexuality to survivors of sexual abuse involves sharing basic information and permission within a context of giving affection, because what survivors learned and experienced regarding sexual bodily response was steeped in shame and misinformation. Often there were implicit messages that one must barter one's body for safety. Any act of kindness by an authority figure is suspected of leading, sooner or later, to a demand for "payment." Sexual interaction is not perceived as an autonomous act for self but rather a choiceless, conditioned response to certain stimuli.

Much of the possibility for healthy sexual functioning involves unlearning the lessons of trauma and learning anew about respect for the body, entitlement to boundaries, intimacy as a function of consistent respect and earned trust, and sexuality based in sharing and safety rather than in coercion and victimization.

At some level, before we can learn to trust another, we must be able to trust ourselves. A survivor who feels unentitled to say no cannot afford to say yes. A survivor who chooses partners out of trauma bonding to the original abuse continues to be in danger. A survivor who relives rape with every sexual touch cannot feel safe enough to explore his sexuality. A survivor who is continuously at war with her body cannot also be its defender. Polarized internal parts of self need to learn to separate past

from present, and perpetrators from safe partners. Therefore, establishing intrapsychic intimacy, i.e. liking and comforting oneself, is an important requisite for intrapsychic intimacy.

SEX THERAPY AND THE DEVELOPMENT OF THE REAL SELF

To be intimate and sexual in a healthy way with another person requires a degree of vulnerability and trust between two people. If one partner is dangerous or moves destructively toward, away or against a person, such intimacy is not possible. Often individuation is blocked, and the individual feels lost, not knowing who they are, or what they want, and lacking clarity regarding values. They verbalize "feeling like an imposter," mostly influenced by those around them. Development of the "real self" must be facilitated to allow integration of one's past, present and future for healthy intimacy and sexuality to unfold. Unfortunately, many individuals never fully establish this developmental milestone of adulthood.

Masterson [17], operationally defines the "real self" as listed in Table 2. The goal of therapy with a survivor who has a dissociative disorder is to establish a "real self" and then to find a partner and establish a high degree of intimacy, passion and commitment in the relationship. But establishing committed relationships and friendships are only part of recovery. As Masterson recognized, recovery also entails the ability to experience the full range of human emotions while being effective, masterful and powerful in carrying out daily transactions. Such goals need to be part of an overall treatment plan.

Dissociation narrows the consciousness and leaves the individual numb and vulnerable. Self development includes intracommunication, consisting of meta cognition that helps the individual know their own mind, the mind of others somewhat, and to make reasonable assumptions about the world around them. Mindfulness exercises and basic psychotherapy allows the individual to become more aware and capable of choosing partners that do not duplicate their abuses.

Finally, blocks to self development require trauma resolution therapies, generally focused on exposure to traumatic events with the capacity to have one foot in the past and one in the present. Trauma work is always focused on integration, i.e. re-owning disowned parts of self. Affect and cognition embedded in the therapy allow for connective emotional experiences and the challenging of cognitive distortions. As amnesic barriers break down, and the individual is able to integrate and fully process a cohesive narrative, their capacity to experience fully is repaired and enlarged.

Table 2: Defining the Real Self (Masterson, 1985)

1.	Experience emotions, pleasant and unpleasant
2.	Expect appropriate entitlements
3.	Capacity for self-activation and assertion
4.	Acknowledge self-esteem
5.	Sooth painful feeling
6.	Make and stick to commitments
7.	Creativity
8.	Intimacy
9.	Ability to be alone
10.	Continuity of self

INTIMACY STYLES AND PAIR BONDING

Intimacy is the capacity for healthy bonding, closeness, connectedness, and self-disclosure with a reciprocating partner. Intimacy is greatly impaired when the cognitive schemas for trust, safety, esteem, empathy, and power are injured. Two types of components create the construct of intimacy: intrapsychic and interpsychic. In the intrapsychic ("within") components, traumatized individuals perceive themselves as damaged, defective, unattractive, unintelligent, and so on. They are therefore impaired in finding healthy pair bonds.

When a pair bond is established, one's intrapsychic intimacy tapestry is superimposed on the other's, creating a complex interweaving of interpsychic intimacy. Sometimes therapists can focus on individual intrapsychic intimacy and help restructure the behavioral interchanges of couples through "facilitating positive interchanges" [18,19]. Intimacy can also be strengthened by teaching problem-solving skills, active listening skills, language, the expression of feelings and desires assertively and directly, and so on. Although this is necessary for healing, given the relationships that trauma victims create, it is rarely sufficient.

Sexuality is one manifestation of intimacy, which includes the capacity of each individual to tolerate the vulnerability, closeness, trust and perceived release of control inherent in sexual interchange, as well as the fluidity of closeness and distance inherent in the sexual relationship. If two partners live as roommates with little intimacy, it would be unrealistic (and perhaps pathologic), to expect passion and vulnerability in the bedroom. Therefore, sexual dysfunction is often a result of the eventual atrophy of intimacy with one or both individuals.

It is unrealistic to expect an individual raised in a dysfunctional family system to know how to create healthy boundaries, communicate, manage anger, problem solving and master other skills requisite for an intimate connection. A compilation of sex and marital therapies that include components of submission and information-giving should be provided simultaneously or sequentially with attachment intervention.

SUMMARY

The dearth of clinical material on treatment of sexual difficulties in sexual abuse survivors may be due to the complex nature of effective treatment. Restoring healthy sexual desire and behavior in survivors requires the clinician to integrate sex therapy, treatments for trauma and dissociative disorders, and somatic, cognitive behavioral, psychodynamic, and couples' therapies. Time is also of the essence. These models should be applied within a brief therapy window, since many of these troubled relationships could not survive long-term therapy. While difficult, our experience has shown that success is possible. Our clients are able to somatically integrate their trauma history, learn intimacy skills and effective communication, and achieve healthy, mutually beneficial sexual interaction.

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