POST-TRAUMATIC STRESS, SEXUAL TRAUMA AND DISSOCIATIVE DISORDER: ISSUES RELATED TO INTIMACY AND SEXUALITY

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SECTION 1: STRESS RESPONSE CYCLES, DISSOCIATION AND SEXUALITY: INTRODUCTION

When overwhelming stressors occur acutely or chronically, the natural biphasic response, both psychologically and physiologically, is numbing, avoidance, amnesia and adhedonia that cycle intermittently with intrusions of affect and memory, hyperreactivity to stimuli and traumatic reexperiencing (Horowitz, 1986). During the numbing phase there will be avoidance, detachment, emotional constriction and depression. Because of the high level of fear and avoidance, there is time-limited gradual revisiting of the event, directly or indirectly, until it is mastered or completed. Inability to work through the overwhelming experience successfully (as might occur in the case of traumatized young children without supportive nurturing parents) may result in intrusions. These intrusions may take such forms as visualizations of the event, a "bleeding through" of intense affect such as sadness or fear on a chronic basis and/or a tendency to recapitulate aspects of the trauma developmentally - "dedicating" one's life to reliving the event in disguised forms. Physiologically, the system will cycle with hyperarousal states which the individual may experience as terrifying or exciting, as well as providing a relief from the depressed, numbing, constricted states. Hypo- and hypersexuality may alternate concomitantly with these changes.

When trauma has included sexual abuse or rape, the numbing and intrusion symptoms typically involve body sensations and somatic complaints, as well as sexual desire, arousal or orgasm. In addition, if the violation is by a caregiver or by an older person towards a child, there commonly are developmental influences to the unfolding sexual and affectional systems. Traumatized individuals may develop a sexual desire

disorder with hypo-, hyper- or asexuality. Hyposexuality is evidenced by low initiatory behavior, while hypersexuality employs frequent sexual initiation as a means of dealing with most negative affective states, including loneliness, fear and sadness. Asexuality typically results from extreme fear of bonding with others, extreme narcissism which results in an inability to genuinely care for or empathize with others and/or severe repudiation of one's genitals, sexual arousal or gender. Often individuals with hypo-, hyper- and asexualities will utilize imagery to distance themselves from others and thereby deal with fears of intimacy. Frequently hypersexual individuals will become hyposexual as their alexithymia is reversed, and they consciously experience fears related to bonding.

Mediating the link between trauma and sexuality is the phenomenon of dissociation. Dissociation is a safety-oriented cognitive mechanism in which the individual attempts to avoid memories or affect that "disrupt the psychic equilibrium" (Wilson, 1989). With dissociation there may be reality detachment - events are perceived without emotions, the self becomes robot-like and others are depersonalized objects. Since the individual feels like an object, he or she may be able to respond sexually, even to the point of orgasm, by "bypassing" desire or arousal. These men and women are able to have sex with the other person's body without affection, intimacy or even liking the partner, by focusing on body parts such as breasts or genitals rather than on the whole person. In effect, they are using the other person's body to masturbate. Alternatively, they may fantasize a pornographic scene and have sex with a fantasy partner rather than the person. Thus, dissociation serves the function of distancing them

since becoming too close or dependent on others may be registered by the traumatized individual's brain as dangerous. Also, distancing oneself allows the individual to maintain the depersonalized state, and therefore not think or feel about past traumatic events.

Dissociation also involves partial or complete memory loss, misperception, misappraisal or misattribution of ongoing events (Briere, 1992). The individual may "space-out" or shut down or act or look like they are feeling when they are not. The dissociation allows analgesia and protection both during the post-traumatic event and later, ensuring that the victim maintains a sense of control, even though events are in reality out of control. Sexually, the body may experience analgesia and the hyposexual individual may report that they "feel nothing". Van der Kolk (1989) has reviewed the extensive literature of endogenous opiods secreted chronically after prolonged exposure to severe stress. In veterans, he documented opiod-mediated analgesia two decades after the original trauma, which was equivalent to a secretion of eight milligrams of morphine. Touching a partner following a period of early prolonged or extreme trauma or neglect may therefore be experientially blunted like touching an inanimate object. There also may be genital anesthesia. Erection and lubrication may be inhibited by the terror, which the individual is not consciously experiencing. Also, the individual in an over-controlled state may be unable to "let go" and therefore any accumulated vasocongestion may not result in orgasm.

Braun (1990) has conceptualized dissociation of behavior, affect, sensation and knowledge (or cognition) as the BASK model. Examples of behavior include

disorientation to place or person or to visual, auditory or tactile cues. Sexually, examples include men who perform anonymous sex with strangers whom they often do not like or find attractive, men who put their penises through holes, without knowing who is on the other side, for the purpose of oral genital contact, or women who function repeatedly as prostitutes. Typically, such dissociated behavior is trauma-bonded (Schwartz, Galperin & Masters, 1993) - i.e., the compulsive behavior serves as a reenactment of the original trauma. A part of self will revisit the experience of childhood rape repetitively, to repeat the danger and excitement, in an attempt to complete the stress response cycle.

Dissociation of affect might include experiencing feelings of terror, numbness or confusion without any apparent cause, or affect incongruent with the present situation. Endemically, many men in this culture highly dissociate from affect, unaware of a myriad of emotions. Feeling distance and disconnection from their partners is experienced as a need for ejaculation. Some individuals can have sex without affection because of dissociated affect. On the other hand, a person might experience sexual apathy or impotence because the individual is terrified but unaware of it. Unable to use fear or terror as a signal, some individuals attempt to "perform", but the genital vasocongestion is blocked by the fear.

Dissociation of sensation may include numbness, headaches or sickness or pain in the pelvis with no medical explanation. As stated, one may touch their partner sexually and have the same experience as touching an inanimate object - numbness. The sensations of the body with sexually traumatized people are particularly prone to

dissociation because these individuals may believe the body is the source of their badness (i.e., it's because of my body or my sex organs that I was raped). The latter would be an example of knowledge that has become dissociated. Other examples of dissociated sensations that are common are out-of-body experiences such that the individual "leaves" their body during sex and watches from the ceiling, thus feeling numb.

Dissociated knowledge might be manifested by the belief that a rape didn't happen to "me", it happened to the body or to the genitals as a way of coping with the overwhelming terror. The cognitive system shuts down, and the individual then disengages each time he or she has sex and lends the "body" to his or her partner. This exemplifies another critical component of dissociation, which is fragmentation of personality. Whenever a traumatic situation occurs, the event is encapsulated by the dissociative process and a semi-permeable membrane develops around the event that only allows some information in and out. For example, if a child is age six at the time of sexual abuse, there will be an encapsulated trauma-bonded six-year-old-self that is impervious to future development (Schwartz, Galperin & Masters, 1993). This part of self is described by Watkins and Watkins (1988) as an ego-state. Encapsulated within the ego-state is cognition, affect, sensation and knowledge of the six year old. When trauma is very severe and/or occurs at a young age, the ego states are even more distinctive and become the alter personalities of the patient with a dissociative identity disorder (DID). This ego state or alter may believe that it can still be raped at any moment, that danger is imminent and they are at fault. Typically, when there is severe early trauma, there is a robot "depersonalized" part of self that has endured the rape, and an affective

part of self that holds the rage and sadness unable to be expressed. Two additional parts usually manifest themselves following severe trauma. There is a part that takes care of the person which developed when no caretakers were available, and an executive part that functions to please, caretake and go to work. This part is highly reactive to others.

Because of this compartmentalization of personality, which once allowed the individual to survive, there now are parts of self that may have conflicting needs. For example, one part may want sex, but another is terrified of sex, and still another is rageful about repeatedly being treated unfairly. These parts of self may act autonomously to encourage self-destructive behavior which the executive part of self may know will lead to harm of the self or others. Thus when a loving, caring partner approaches the person for a relationship, another part may sabotage the budding relationship to protect the individual from anticipated abandonment or pain.

Since parts of self may have limited information because of amnesic and dissociated awareness, they can interpret their needs only narrowly relying upon the logic of the encapsulated abandoned child. When the parts of self feel sad, the executive self may get a signal to eat; or if they feel lonely, the signal may be to have sex; or if they become terrified, the executive may be urged to seek drugs or alcohol. Thus, strong emotions may trigger addictive behavior even when the consequences to the executive adult self are destructive. Emotions may trigger unresolved, unmetabolized past trauma, causing a leakage or intrusion of the cognition or affect into consciousness. The individual will feel out of control and reinitiate the illusion of control by obsessional

thoughts or compulsive behavior. This "illusion" is the momentary, extremely reinforcing and quite likely endorphin-releasing experience that results from revisiting the illicit danger. Thus, the obsessions and compulsions provide a relief from the pervasive pain of disconnection and chronic dysphoria. The acting-out behavior and revictimization of self is a form of "physiologic masochism" which is one of the long-term effects of severe early abuse and neglect. Ultimately, resolution of past trauma and integration of the split off parts of self are essential to stop the numbing and intrusion cycles and resultant self-destructive behavior.

SECTION 2: SEXUAL UNFOLDING AND THE DEVELOPMENT OF LOVE MAPS

Sexual desire, arousal and orgasmic response are natural functions that unfold both physiologically and psychologically throughout childhood and adolescence. Each person follows his or her culture's script that dictates sexual desire in specific situations and stimulates sexual response to certain individuals and images. John Money (1986) has used the term "love map" to describe such images and behavior:

> A love map is not present at birth. Like a native language, it differentiates within a few years thereafter. It is a developmental representation or template in your mind/brain, and is dependent on input through the special senses. It depicts your idealized lover and what, as a pair, you do together in the idealized, romantic, erotic and sexualized relationship. A love map exists in mental imagery first, in dreams and fantasies, and then may be translated into action with a partner or partners.

The factor that initially influences love map development during childhood is the presence or absence of adequate parenting, caretaking and nurturing. These, in turn, strongly influence the capacity to master the environment, self-efficacy, self-esteem and

the ability to establish and maintain close attachments. Adequate parental or substitute role models allow a person's gender identity to unfold within established cultural scripts. Social interaction with peers provides skills and integral feedback for developing affectional systems. Genital rehearsal by self-touch and exploration of bodily sensations then provides individual biofeedback, which allows the person to integrate his or her unfolding sexuality with developing personality.

Love maps may be "vandalized" (Money, 1989) by "sex-negative" antecedents which are "traumatic, disciplining or stigmatizing". Traumatic antecedents may result from rape, molestation or from witnessing family members being sexually abused. Discipline may occur verbally or physically by punishing "natural" manifestations of sexual unfolding such as masturbation. Stigmatization may result from perceived shaming, ridiculing, isolation or selective treatment of an individual because of their body or behavior.

As a person matures, sexual desire and arousal can become a natural manifestation of attraction to a person perceived as appealing if the developmental love map is not seriously vandalized.

Once a pair-bond is established, sexual desire is a natural way of expressing the sense of intimacy that develops within a committed relationship. Therefore, anything which enhances or inhibits relational intimacy may positively or negatively influence the individual's levels of sexual desire or arousal. Sex is innately pleasurable - unless something mitigates that pleasure. Also, persons who are situationally bored, pressured, fatigued, angry, guilty, fearful, anxious or suffocated in a relationship are "entitled" to low

levels of sexual arousal (Apfelbaum et al., 1979). Couples who evidence little intimacy in the living room typically will feel distant from each other inside the bedroom, unless impersonal sex or conflict has become a source of arousal. Often individuals with a history of trauma find partners who also have experienced severe trauma (Carnes, 1992) and then develop a history of destructive transactions between themselves which interfere with sexuality even more.

Vandalized Love Maps

Like native language, the social and sexual customs of a culture are programmed-in after birth into an actively differentiating central nervous system. Sexual behavior seems to remain in a state of hibernation which can be awakened at different ages depending on the individual or the culture. Typically there are individual genital rehearsals before age 5 and erections and vasocongestion of the pelvis are normative (Schwartz, Money & Robinson, 1981), particularly with adequate holding, touching and nurturing from caregivers (Spitz, 1945). The pubertal hormones then activate the love maps which have developed throughout the first decade of life. Social customs such as the recent deluge of media related to sexual behavior and romance may stimulate the program earlier. The trends for initiation of teenage sexual intercourse have changed radically since 1950, so that it is normative for boys and girls to initiate sexual play soon after puberty. It has also been hypothesized by Money (1986) that sexual stimulation may alter the brain, as evidenced by the age of puberty decreasing over the past forty years as kids are sexualized earlier.

Sexuality can also awaken prematurely due to sexual trauma. The sexualized child will often have sexual urges too early to integrate into the developing personality and without cognitive preparation or guidance. It is as John Fowles described metaphorically, "like a ship sent out to sea without a rudder". Thus, like a child who has precocious puberty, the sexualized child finds that socializing with same age peers is uncomfortable and therefore remains isolated and vulnerable to atypical socialization and revictimization by destructive sexualized relationships.

Whenever sexuality awakens within a context of exploitation, hatred, violence or shame, it is disruptive to the basic schemas of cognitive development of the child - esteem, trust, safety, power and intimacy (McCann & Pearlman, 1990). Development of the capacity for empathizing with others is also impaired, and so, the child remains the center of its universe. With trauma and in the absence of emotionally relevant social support, both the core sense of self and the idealized internal representation of the caretakers are disrupted. This results in the individual clinging to idealized object and grandiose self-relation units for self-preservation (Barnard et al., 1992). All these impaired developing cognitive systems influence social relations, intimacy, sexuality and the capacity to pair-bond. Additionally, the sense of self is organized around sexual stigmatization and shame, i.e., I'm different, defective or injured because of my gender, body or sexuality. Therefore, activation of sexual arousal elicits sexual shame so the person is reminded that they are "bad" because they feel sexual, or because they have genitals or because they are male or female.

The following description from a taped therapy session with a sexually compulsive ego-state (discussed in the previous section of this paper), accessed under hypnosis, clearly depicts how parental neglect can influence the developing love map of a seven year old boy. This individual presented in therapy as an adult with compulsory sado-masochistic sexual behavior with a prostitute. Under hypnosis, the client scanned for "any event that can help you understand your arousal to having pain inflicted upon you". He remembered his mother leaving frequently for extended periods and her multiple affairs. The following is his "encapsulated distorted" thinking about sexuality:

> Sex is dirty. It feels good but I don't want no part of it. It only makes life miserable. Your penis will fall off if you have sex too often. All it's good for is causing trouble. You can't feel sex, you can only hurt it. After all, my Mom uses it to fuck my Dad and Billy. That's all the men are good for, so Mom can fuck them. Well, fuck them all, I don't want sex. It's evil and good for nothing. It only makes me feel bad. It's why Mom is never home, she's out fucking and hurting men. I wonder if she has other kids. I hate sex. If I cut off my dick, Mom would like me better. She hates boys - she just wants their dicks. She keeps them on her trophy shelf. Billy and Dad are fools. They think she wants their stupid useless dicks. Well, everyone knows that they're ugly and should be cut off. I'd cut yours off if Mom asked me too. After all, what's it good for? It just gets you in trouble. That's why Mom liked my sister Julie more. She doesn't have a dick. Girls always call the shots - you can't put your stupid dick inside of them unless they let you. And they only let you if you beg and plead. And you're good at that - because you can only please Mom by giving her your dick. She makes you such a fool. Sex is her toy to enslave me. She uses it to control Billy and my Dad. And they hate her, but because of sex, they are tied to her. What weaklings they are. If they would stop wanting to have sex, then she could not control them. They're like robots, she pushes their buttons with sex. They're idiots and deserve what they get. She doesn't do anything and they follow her sex smell because they have no brains. I like beating off with Billy. The sperm goes right

> where it belongs - in the toilet. I always want Billy to beat me off - he really does it good. See, sex is dirty, but we need it to survive.
>
> Serves him right - she was just a cocksucking tease. She made us beg for her attention and then she just took our dicks off. That's all we are to women - just a sex thing for her to torment. We deserve the torment, deserve the laughter.

The client's love map which includes sexual desire and arousal to having prostitutes verbally and physically abuse him, seems to follow directly from the childhood experiences of (1) extreme neglect by both parents, (2) mother frequently abandoning the children and having frequent sexual affairs, and (3) confusion over her lover, Billy, moving into the house while the father lived there. He needed his mother who he perceived as wonderful and she hurt him, while his father seemed pitiful and neglectful, which led to his repudiating aspects of masculinity and eventually cross-dressing as a child.

From this example, it becomes more obvious that integrally involved in the love map is one's gender identity and sense of self as masculine, feminine or ambiguous. Optimal parental and other role models allow a person's gender identity to unfold within established cultural scripts. Genital rehearsals, including self-stimulation, fantasy and sexual play, as this example suggests, allow the person to integrate his or her unfolding sexuality and developing personality.

SECTION 3: THE IMPACT OF SEXUAL ABUSE ON UNFOLDING SEXUALITY: THE EXPERIENCE OF SEXUAL TRAUMA

When an individual has been sexually abused as a child the only framework he or she has for sexuality is one whose components are brutality, sensation out of control,

overwhelming confusion, violation and ambivalence - particularly if the abuse was at the hands of someone upon whom the child relied. The natural unfolding of sexual curiosity and interest at developmentally appropriate intervals would have been preempted by a premature awakening of genital eroticism beyond a child's capacity to comprehend or manage. Sexuality unfolding for the first time in the context of rape would be like introducing a child to dogs by having a doberman maul him/her. The child, when you said the word "dog" to him would not think of a cute, cuddly, benign puppy, but remembering his own experience, would feel terror and fear for his life. If his first exposure was traumatic in this way, the fear would likely generalize to all dogs, to anything called "dog"; anything vaguely resembling that doberman and the child's response would predictably be an aversion.

When a child experiences sexual abuse, there is overwhelming confusion. Not only can the child not make sense of why this is being done to him/her, but likewise the child can make no sense of the myriad, sometimes conflicting sensations caused by what is happening. Further complicating matters, perpetrators of child sexual abuse often say things in the course of the abuse or just after such as:

I know you liked that.

You're a bad/naughty little girl/boy.

I do this because I love you - you're my special one.

This is good for you.

Now you'll know what not to do.

I have to do this to teach you a lesson.

Your mother won't do this, so you have to...

You're a little whore; that's all you'll ever be.

The child often construes the sexual abuse as punishment and wonders what he or she must do to be better so as to avoid this horror in the future. When child sexual abuse occurs at the hands of a parent, the internal conflict the child experiences is of an even more immense proportion. Because the child must depend on his or her parents for all forms of sustenance - literally for life itself - the child even more conclusively blames himself for what is happening.

The bodily sensations are themselves terrifying. The child no longer has control of his own body - he learns that at any time a more powerful other can appropriate his body and make it act in any way he (the perpetrator) chooses. He learns that bodily responses too complex to comprehend can be evoked from him entirely at the whim of another and that he is and can at any time again be at the perpetrator's mercy. His body is never again his own - it's a defecter gone over to the other side - it betrays him. Now he is at war with his own body.

Some of the confusing sensations may feel pleasurable, and this makes the child feel ambivalent. He may feel ashamed of his body's response as though perhaps it's true he has done something (as the perpetrator implies) to make this thing happen to him. If he lives in a family where no one touches anyone in a loving, healthy, comforting way then he is already starved for touch, since it is a most basic human need. When this annihilating touch with its fleeting moments of pleasant sensation is the only available tactile human connection, the child may indeed learn to seek it out eventually. In no way would this constitute the child desiring to be raped, but rather reflect the tremendous environment of deprivation against the backdrop of which the abuse takes place. The child may likewise learn that compliance makes what is inevitable less brutal, i.e. he doesn't have to be beaten, burned, choked or smothered into submission if he'll just lie there and let the perpetrator have his way.

Splitting and Dissociation

As a consequence, the child may initially attempt to focus only on what is pleasurable. Since this is like searching for a needle in a haystack, the child usually will of necessity find some mechanism of splitting off from the body to which the abuse is happening. The child may sing to himself, put himself in trance by repeating a word or phrase, do multiplication tables in his head, focus on the colors he can see as though entering into those colors. The following is one individual's dissociative trance following her parents' slaughtering of her dog Petey and sexually abusing her. She was told that the dog was killed because she wouldn't lie still.

> It was because I couldn't lay still when she was putting that thing in my pee-pee. I sat in my bed eating chips and

> wondering who was going to help me, eating peanut butter to take the taste of her pussy out of my mouth, eating more peanut butter because I can't get the taste of Petey's blood out of my mouth. Counting all the holes in the ceiling, wondering who I was going to talk to, eating handfuls of raw oatmeal, wondering who was going to sit with me in the window, wondering if I'd really, really had enough goodness in me to lay really still. I remember eating peanuts one by one counting them as I went 380 peanuts all together. I ate them. It was ending the loneliness and guilt for having Petey slaughtered in front of my eyes. Watching his throat being sliced and 380 peanuts later I decided it was my fault, and I wanted my mouth to be drenched in his blood, in my mouth I wanted to be back in the blood, I was bad. I felt like I was a fat bitch and I felt guilty for having the need to eat the candy, I didn't deserve to have the food I had, I was very bad, 12 x 12 = 144, 12 x 6 = 72, 12 x 3 = 36 - half of half. I wanted to cry, because I didn't have any tears I was afraid to cry, I hated the idea of who was going to protect me after my father left my bed at night, Who was going to be there to pet when they brought back to the house in the wee hours of the morning, Who was going to lick my face and make me giggle, No one I was alone, totally alone 12 x 4 = 48, 6 x 6 = 36 - no one. I want to cry but I'm afraid - I'll eat that's what I'll do I'll eat this and it will make me feel good to have this in my belly.

If the abuse becomes more torturous, as in this example, the numbing and splitting off from bodily sensation must by necessity become more extensive. The child feels him or herself float up and look down from the ceiling with detachment at the poor child being raped on the bed. When sexual abuse is brutal and frequent and the child has less and less hope of actual escape or rescue, the splitting must be used as a habitual coping response. The child, if imaginative, may create a substitute child out of this experience of trauma-induced depersonalization. As he has the experience that many rape victims describe of standing or floating outside of the violent proceedings, he finds it self-preserving to imagine that the child he sees being brutalized is not him. In this

manner the child's desperate attempt to convince himself that: "it's not happening" gives way to "well, at least it's not happening to me". With continued abuse, the split becomes strengthened, the personality fragmentation more rigid. The part of self perceived as separate may encompass and contain part or all of the child's memory and response to the abuse, leaving the child free to function semi-normally or at least with less devastating impairment. The child may perceive this part of self as bad but separate, and after even more abuse rigidifies the barriers to conscious perception, the child may even cease to perceive the presumed "other" at all. When situations mirror significant elements of the abuse or relationships recapitulate its dynamics, or more rapes occur, this part of self is automatically activated to cope with what it was originated to deal with that a single terrified child could not.

What has been described is a child's use of dissociative defenses. When ongoing abuse makes these defenses habitual, a dissociative disorder results. When abuse is extreme, brutal and unceasing, the degree of the dissociation required to cope with it becomes greater and the result may be dissociative identity disorder which implies a more rigid encapsulation and lack of integration of the traumatic event(s), feelings, responses and implications. Despite this effective internal containment of the traumatic material outside of consciousness, the child will typically still evidence symptoms of the abuse: bed-wetting well beyond the normal age of cessation, compulsive genital self-stimulation, drawings, doll-play or play with peers reflecting themes of abuse or rape, chronic nightmares, chronic anxiety and hypervigilance. Sometimes children will hurt

animals or siblings or begin to touch (often) younger siblings or peers in the same confusing ways they have been touched.

It is not within the child's capacity to understand why he behaves as he does, why he feels terrified or angry, why he feels bad and different, why he wets the bed and the other children don't. Even if the child retains awareness of the abuse, he will not code it as abuse or understand its connection to his symptoms. Rather his symptoms will serve to confuse and stigmatize him, further increasing his isolation, shame and innate feeling of badness.

Clearly, all of the aforementioned factors have a profound impact on the unfolding of gender identity, on the formation of cognitive schemas relative to safety and power, upon the creation of constraints to capacities for bonding, upon identity formation including sexual identity formation and as a subset of the latter, arousal patterns.

Trauma Bonding

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. This phenomenon in its myriad manifestations is known as trauma bonding (Hindman, 1992; Schwartz, Galperin & Masters, 1993). The most damaging fusion of elements perhaps is the pairing of terror with sexual arousal. One DID client described how she experiences this phenomenon relative to the responses of her internal system:

> I don't know that we've ever experienced true sexual arousal - only fear arousal, arousal driven by terror, anxiety or excitement that is basically over-stimulation. When we feel these, it translates into a physical response in the vaginal

> 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 the limitations of a child in terms of processing and coding overwhelming sensory-affective experiences. When an adult sexually abuses a young child the child does not perceive what is happening as sexual. He sees threatening movement, objects and shapes coming at him too fast. He feels overwhelming stimulation - too much too fast to process. He is flooded, immobilized, panicked. Psychologically he is catapulted beyond any known frames of reference. He has no basis for understanding these actions. He can't breathe, his body is crushed under adult weight, his orifices are violated, he thinks he will die. And amidst all this annihilating havoc, there is the birth of sexual arousal, 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 he feels scared he feels arousal. Since there may be many scary things in the environment of a child being chronically sexually abused, he is often scared and may begin to touch himself or move in ways that provide some temporary resolution of this genital sensory overload that continues to occur out of nowhere in his perception. The child does not know what he does as compulsive masturbation - he simply seeks relief from what is overwhelming him sensorially. If in response he is punished or humiliated or his actions used by the perpetrator to convince him he "wants" more abuse, then the damage is exponentially compounded.

One "solution" to this situation of irreconcilable conflict and shame is that the DID child may split and create an alter personality who 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 further, claim to view the perpetrator as an ally, or "my only friend".

This adaptation is not uncommon when the sexual abuse is escalating and at the hands of a particularly brutal father or father figure in a context of little available nurturing by other caregivers. It permits the child not to 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, even after the abuse which originated it has ceased (i.e. into adulthood). In so doing, the self-attributions of badness become increasingly entrenched and the individual as a whole winds up in circumstances likely to culminate in revictimization after revictimization.

Prerequisites for Healthy Sexuality vs. Trauma Learning

In order to feel intimate with another individual one must feel safe. Simply lying naked next to another person involves a tremendous degree of vulnerability. Ideally one has to feel that his being, both physical and emotional, will be respected. In order to transcend the physical boundaries which separate two bodies with safety, one must initially feel a sense of and a right to bodily and emotional integrity. One 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 who has known sexual unfolding in the context of violation, these are foreign concepts. Sensation has been annihilating, feelings suppressed, comfort and pleasure an illusion quickly giving way to escalating danger. 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 robotlike endurance of an act of violation and devastation.

Teaching healthy sexuality to survivors of sexual abuse must necessarily involve basic information giving because what they were taught and what they experienced in terms of sexual bodily response was steeped in shame and misinformation. Often there have been implicit messages that one must barter one's body for safety such that any act of kindness by an authority figure becomes interpreted as something sure to be followed (sooner or later) by a demand for "payment". Sexual interaction has not been perceived as an act for self but has come to be in essence a choiceless conditioned response to certain stimuli. One client described it as follows:

> As a child, we always had to be ready...it was better to want to cause they were going to anyway. Rape hurts more than making yourself believe you want to do something when you really don't. Now, (as a result) the least indication from someone and we feel sexual toward the person even if we are not attracted to them. It's confusing cause we're not sure if we're responding out of our feeling or its an automated response system to some subtle signal from the other person...
>
> ...For us a core belief has been that no one will care for us unless we're sexual with them. At age 18, we were sexual with anyone we even became remotely emotionally close to.
>
> In present relationships, learning about how to set boundaries permits us to risk. If we can't say no, we can't afford to be in a relationship. It's not the other person we're afraid of now; it's ourself because we don't know emotional connection without it triggering the idea of being sexual.

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 one can learn to trust another, one must be able to trust himself. A survivor at war with his body cannot be its defender. A survivor still feeling unentitled to say no cannot afford to say yes. A survivor choosing partners out of trauma-bonding to the original abuse will be in continuing danger and a survivor who relives rape with every sexual touch is not yet safe enough to explore.

The Body

Many survivors of childhood sexual abuse go through life hating the body. It is far easier, after all, to hate and blame the body than for a child to acknowledge that an adult whom he trusts or upon whom he relies has used his as an object, as a receptacle. The survivor may hate the body, punish the body or merely try to remain separate from the body, i.e. my body's theirs (the perpetrators) but my mind is still my own.

One male DID client described his seeing his own body typically as that of a child although he is now adult. When he bathes or otherwise has occasion to view for more than a moment his adult male genitalia, he is alarmed. He does not recognize it as his own but rather his associations are to his perpetrator's genitalia. At these moments, he is often overwhelmed with an almost uncontrollable urge to sever the penis from the body and must strive mightily to restrain himself and to remind himself over and over that the consequences of doing so would be life-threatening.

This may seem an extreme example, but the degree of estrangement from the body or rejection of bodily aspects which to the survivor feel inextricably associated with the abuse is not unusual. To expect the survivor to make a leap from the repudiation of the body the abuse has wrought to seeing the body as his own, much less as a potential source of pleasure or sexual intimacy is unrealistic. Particularly for DID clients whose identity, including bodily identity, has become so fragmented in response to severe abuse are the issues around body image and acceptance profound. Various alter personalities may have very different feelings toward and views of the body. Some personalities may feel they are male and see the body as male whereas others whose gender identity is female see the body as female. Certain alters may embody the somatic aspect of the abuse and their experience of the body is of endless pain. Other alters may have formed in response to pain beyond a certain threshold, and their sense of the body is of pervasive analgesia. Reclaiming and reowning the body for most survivors must occur bit by bit. The process involves elements of trauma resolution work, correcting cognitive distortions based in trauma learning, work around body image often involving expressive work and graduated behavioral tasks and finally, integrative work aimed at bridging the fragmentation and rejection of physical self resultant of the abuse. It is a delicate process which forms the foundation for eventual exploration of non-abusive, non-exploitive sexuality.

Flashbacks

Even when the terror, confusion and sensory overload engendered by the sexual abuse has been compartmentalized through a dissociative process, being touched in a

sexual way can for many sexual abuse victims unleash a flood of intrusive feelings, sensations and images. Like a Vietnam veteran hearing a "chopper" overhead and running for cover long after the war has ended and he's home, so too the survivor of sexual trauma reacts automatically to echoes of original traumatic events. When approached even by a trusted loved one in a sexual way, he or she may struggle, cry, thrash as if held down or attempt to hide or otherwise escape. These flashbacks to prior sexual victimization often cause the person to feel "out of control" or "crazy" because they seem to come out of nowhere and because the danger feels so real and immediate. For a subset of survivors, this type of flashback is kept at bay by a pervasive numbness. The body itself may become virtually devoid of feeling as a sexual encounter is approached. This numbing was often the response to the original abuse and any similar touch again activates it. Thus, in essence the person is still reliving the trauma in response to being triggered. They are simply reliving a later phase of the original traumatic event by reliving their dissociative response to it.

A third coping mechanism which may have evolved over time as an attempt at mastery but shaped by trauma-bonding is a compulsive, driven sexuality that constitutes a replaying at some level of the or an original rape scene but this time, with some illusion of control. The individual may seek out a partner who will do to them that which was originally paired with unfolding sexuality. Alternatively. the individual may "fantasize" violent or pornographic images in order for arousal to be achieved and in order to maintain distance from partner - if they are merely two objects interacting it feels less vulnerable. Often the victim of repetitive early abuse will have come to some implicit

awareness that following enough pain will come a calm detached feeling (which is in actuality what does occur physiologically) and so will seek pain in order to attain numbness and escape. These tools enable them to be sexual but serve to further entrench the sexual shame engendered by the original abuses (now being recapitulated). It is interesting to note that many survivors of sexual abuse who are sexually compulsive (i.e. with compulsive masturbation, anonymous sex, sex involving extreme bondage or infliction of pain) do not appear the least fearful so long as the compulsive or violent component is present, but placed in a situation of physical intimacy with a safe, trusted partner and asked to explore some non-genital sensual touching, the terror that breaks through is off the scale. Objectification and/or pain reinforces the dissociative defenses - without them to mask it, there is only the excruciating and visceral vulnerability to anticipated harm.

With DID clients, all of these adaptations tend to be present. Often there are child parts whose reaction to sexual overtures is panic. These parts of self may have only experienced sexuality in the context of abuse and have only been present in the body during abuse. Thus their association of sex with violence is total, unmitigated by any subsequent learning since all learning was confined to the traumatic situation. They may be frozen not only in trauma but also developmentally at the level of a two year old, a four year old, a seven year old. Should they emerge during sexual interaction with the DID individual's adult partner, it is revictimizing and given that sexual situations are a likely trigger for switching among alters, their emergence at these times it not uncommon.

When two adults have sex and there is a possibility of children walking in upon them, the responsible precaution is to have the children safely engaged elsewhere and a locked door to prevent accidental intrusion. This same strategy can be employed internally by the DID client by having the child part(s) escorted to a safe place internally prior to adult sexual interaction. Safe place work is an essential prerequisite for sexual trauma recovery generically in that it constitutes a mechanism for self-nurturing and for a redeployment of the dissociative response to create internal calming. Safe place work is also valuable as a method of controlling flashbacks or spontaneous abreactions of traumatic material and as a vehicle for containment and pacing. For DID clients, it can additionally be utilized as a safe internal holding place so that the work or actions of one part of self do not adversely impact another. This separation is a temporary measure to keep the internal system from being flooded or overwhelmed - it relies solely upon the tools the client is already utilizing but redirects them to better serve the goals of titration and pacing which ultimately pave the way for greater internal cohesiveness.

Within the DID system, alters typically exist who feel no pain. These alters embody the dissociative response at its extreme somatically. When they are in executive control of the body, numbness prevails. One DID client described her recollection of the circumstances that created such a part of self. When she was young her father, who was her primary abuser, was content to abuse her sexually without any response from her, but after she became older, he began to demand that she speak certain words and perform certain acts as if she enjoyed what she was being forced to do. The penalty for

noncompliance was severe. Out of this demand was created a part of self, utterly numb and robotlike who could perform on demand yet feel absolutely nothing.

For many DID clients it is this part of self who emerges to "do the dirty work" of having to engage in sexual activity. Because this part is so narrowly focused on the function of emitting the required reaction, it is not equipped to register any aspect of the present interaction as different. Each sexual interaction will continue to feel like just one more perpetration. While very functional in circumstances of sexual violation, clearly this part of self being the responder to sexual initiation by a non-abusive partner is not functional, but rather serves to reprise the victim/victimizer roles of the original abuse with no chance for revisions of the sexual scripting.

Finally, as mentioned, within the DID system there frequently exists an alter or alters who continue compulsively to enact the sexual trauma ad infinitum. This may occur auto-erotically through infliction of pain on the genitals in ways that create the same type or degree of pain experienced in the original trauma: masturbation with hair brushes, curling irons in the vagina, pins stuck in the penis, astringent agents poured on genitals, injurious rubbing, cutting and stretching of a variety of types. For some individuals auto-erotic asphyxiation may be a reenactment of early abusive sexual unfolding in which the individuals were simultaneously aroused and almost choked to death in the context of abuse. Likewise, enactments may occur in ritualized interactions with partners that recreate the pain, humiliation, objectification or power differentials inherent in the original abuse. These behaviors will be among the most difficult disclosures because to the survivor they may feel like evidence of his/her badness or

craziness. In the context of childhood sexual abuse however, these repetitions sadly make sense. Control of such reenactments is discussed in the last section of this chapter.

SECTION 4: INTIMACY STYLES AND SEXUALITY

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 components make up the construct of intimacy. Intimacy involves intrapsychic ("within") components such that traumatized individuals who perceive themselves as damaged, defective, unattractive, unintelligent and so on. They are therefore impaired in finding healthy pair-bonds. Once a pair-bond is established, each individual's intrapsychic intimacy tapestry is superimposed on the other's, creating a complex interweaving of interpsychic intimacy. Sometimes therapists can focus on interpsychic intimacy and help restructure the behavioral interchanges of couples through "caring days" (Stuart, 1990). Other ways in which intimacy can be strengthened include the teaching of problem solving skills, active listening skills, language, the expression of feelings and desires assertively and directly, and so on. Although this is necessary, given the relationships 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 which is inherent in sexual interchange, as well as the fluidity of closeness and distance that is inherent in the sexual relationship. That is, if two partners live as roommates with

little intimacy, it would be unrealistic (and perhaps pathologic) to expect passion and vulnerability in the bedroom. For such couples, sex is a reasonable barometer of their intimacy styles outside the bedroom. Similarly, if they are not friends, or if they have unresolved resentments or active rage, sexual interaction would reflect these problems.

SECTION 5: DEVELOPMENT OF THE REAL SELF

To be intimate and sexual in a healthy way with another requires a degree of vulnerability and trust between two people. Obviously, if one partner is dangerous or moves towards, away or against destructively, such intimacy is not possible. Thus, there needs to be development of the "real self", or sufficient blending, intercommunication and trauma resolution to allow integration of one's past, present and future for healthy intimacy and sexuality to unfold. This is a developmental achievement of adulthood which most couples never evolve to a great degree.

Masterson (1988) has operationally defined the "real self" as listed in Table 1. The goal of therapy with the survivor who has a dissociative disorder is to establish a "real self" to the extent that he or she will be able to find a partner and establish a high degree of intimacy, passion and commitment in the relationship. But obviously, committed relationships and friendships are only part of recovery. As Masterson recognized, the ability to experience the full range of human emotions and experiences, and to be effective, masterful and powerful in carrying out daily transactions is also critical. Such goals need to be part of an overall treatment plan.

TABLE 1

REAL SELF

1. Experience emotions, pleasant and unpleasant.
2. Expect appropriate entitlements.
3. Capacity for self-activation and assertion.
4. Acknowledged 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.

Partner Choices and Interpsychic Intimacy

Figure 1 is a representation of intimacy styles and partner choice. It was devised from Karen Horney's idea that people can move towards, away or against others. Typically individuals who move away are schizoid or avoidant, those who move toward are dependent or histrionic, and those who move against are antisocial or narcissistic. The borderline adaptation is moving towards, against and away simultaneously. The compulsive moves away and becomes obsessive if threatened by dependency needs. The diagram then incorporates Leary's (1957) framework of childhood rearing that characterizes each style of relating. The dependent is conditionally loved by parents, the schizoid is hated as a child and the antisocial is neglected. This diagram is a means of interrelating intrapsychic intimacy styles with interpsychic intimacy styles. Although somewhat elaborate, this system helps predict sexual intimacy between couples (Southern & Schwartz, 1980).

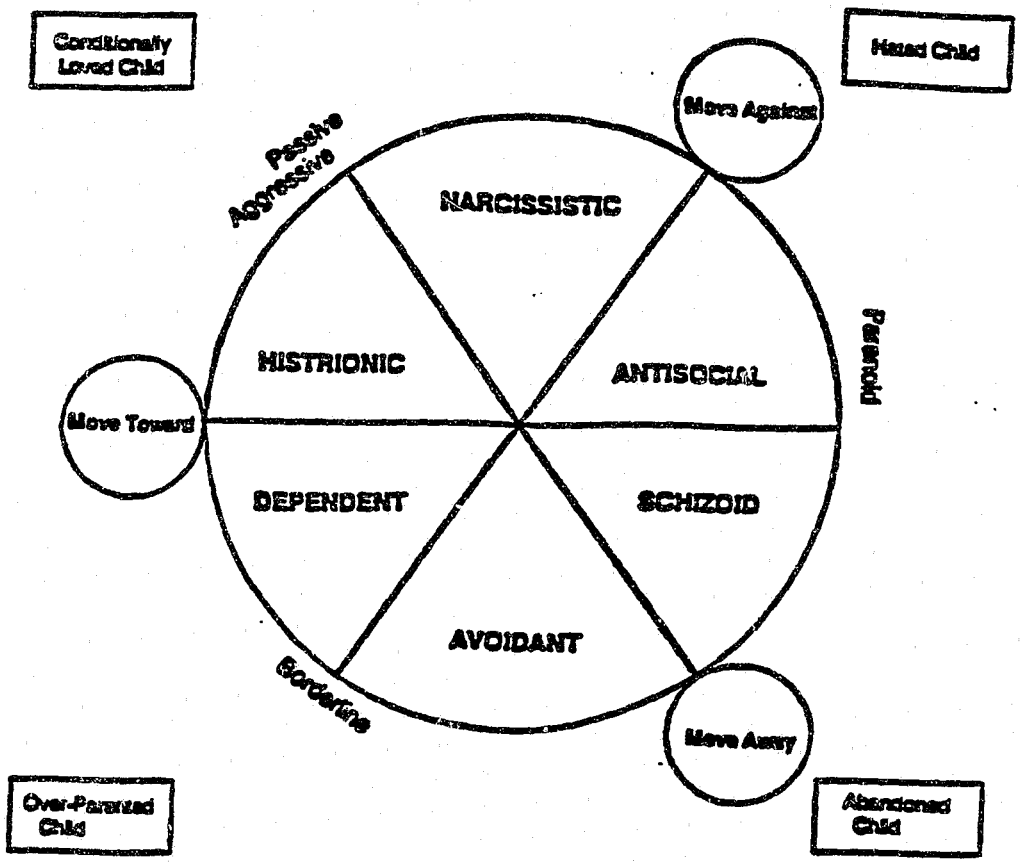
Since many sexual abuse survivors and DID clients have borderline adaptation (Herman, 1992), it can be predicted from this diagram that pairings will often be with individuals directly opposite on the chart, in other words, individuals who are either antisocial (and move against) or dependent (who move towards). Similarly, the hysteric might pair with the compulsive. The question then becomes: what happens when two individuals with borderline and antisocial character styles form a pair-bond?

Often the partner who "moves against" is hypersexual. He or she bypasses the emotional or limbic involvement, and uses sex for nonsexual means - as a release of tension and anxiety, to feel connected and cared for, to escape emptiness and pain and

FIGURE 1

INTIMACY DYSFUNCTION

Steve Southern, Ed.D.
Mark F. Schwartz, Sc.D.



Move Towards: Please partner, superficial emptiness when alone. A lot of shame and anger in exposure.

Move Away: Anxiety and phobias develop as well as somatic disorders when close.

Move Against: Illusion of independence. Power struggles, dominate and bypassing.

so on. Table 2 lists the most salient factors of "sexual addicts" (Letourneau & O'Donohue, 1993), which gives a more comprehensive description of the hypersexual individual.

A common clinical presentation of interpsychic intimacy and sexuality therefore is one partner (typically the male) who wants sex frequently, even several times each day, and the other partner who wants sex infrequently (generally the female survivor), usually less than once a month. The DID client may have parts that move towards, move away and move against. He or she may be alternately hypersexual, hyposexual or asexual depending on the partner, the stage of the relationship or the part in executive control. It is obvious that dealing with the interpsychic aspects of intimacy will be necessary but not sufficient with such a couple. The male will need to begin recovery from hypersexuality by allowing himself to neutralize his alexythymia and therefore begin to think and feel. The female will need to have sufficient trauma resolution and integration to tolerate sexual intimacy without flashbacks and terror. She also needs to move beyond her narcissism to the extent that she will be able to have a greater capacity for true empathy instead of compulsive caretaking.

The problem is, the woman cannot trust and be vulnerable with the partner she chose who is antisocial, nor should she! Thus the therapist must be careful not to encourage intimacy in or out of the bedroom which would be revictimizing - with either partner. It is likely that the partners will stay together and maintain their destructive interchanges. These destructive interchanges will interfere with both partner's individual

TABLE 2

THIRTEEN MOST SALIENT FACTORS OF SEXUAL ADDICTS

(Letourneau & O'Donohue, 1993)

1. Denial and dissociation
2. Avoidance behaviors (due to shame, despair and fear)
3. Delusional omnipotence (controlling that which will achieve the sexual aim of the addict)
4. Narcissism and deception
5. Sexual obsessive and compulsive behaviors (out of control)
6. Risk taking
7. Excessive fantasy
8. Endangering one's professional and family life
9. Tolerating abusive relationships
10. Living a double life
11. Desperate and irresponsible behaviors
12. Lack of appropriate boundaries
13. Decrease in one's spiritual or religious life

therapy, which suggests that sex therapy will not be very useful and potentially harmful. The other alternative is that both people go into recovery. Frequently, the result of this alternative is that both individuals become hyposexual, because to them they do not have the building blocks of intimacy and also because sexual vulnerability is terrifying to them. The third alternative is that the couple separate. They then need anticipatory guidance for future mate choices so they do not repeat the same pattern.

Another common presentation of interpsychic intimacy and sexuality is the sexual abuse survivor and the partner who is dependent and "moves toward". Typically this dependent partner has had a childhood which seems rather ordinary. The parents were hardworking, took care of the children, but, at the same time, had difficulty giving the children time, attention or affection. In other words, attention and affection were conditional on performance (which was never "enough") in the dependent partner's family and the child was neglected. The adult child is unaccustomed to much attention or genuine caring and expects and requires very little. They continually attempt to please the partner and are "very nice", although they harbor passive resentment from a lifetime of unmet needs. In such relationships, the survivor feels a sense of control and does not respect the partner. She or he will often have affairs and victimize the partner in a multitude of ways, and the couple will remain locked together in perpetual conflict. The partner often wants sex frequently, since that is one of the only ways he or she has of feeling wanted and cared for, but is very tolerant and willing to "do without".

For sexual passion to eventually be reestablished, this highly dependent partner, which one might characterize as a shadow of a person, will obviously need to commit to

recovery. In this process, the partner eventually establishes intrapsychic intimacy and can recognize that he or she is worthwhile, independent of the partner. In addition, he or she will also come to know that he or she has the need and right to be cared for, and respected by, their partner and others. With self-respect, the power structure changes in the relationship, and there is the possibility of redefining the relationship with mutuality and passion.

Intrapsychic Intimacy

Linda Leonard in her book The Wounded Woman (1991) writes:

> To protect myself, I led a double life. At school I was a hard-working, serious, straight A student. Though I was the "teacher's pet", I also got along with my fellow students by being pleasing and cheery, shy and adaptive. On the outside I was sweet and serious, but inside was the terrible confusion - the angry hatred of my father, the infinite shame that I was his daughter, and the fear that someone would find out who I really was. The only clues that something was wrong were a nervous facial tic I developed at age fourteen and the fact that, unlike other girls, I didn't date. To protect myself from the frightening chaos of my home - from the violent and parasitic dependency of my father, and the emotional demands of my mother - I resorted to the worlds of intellect and logical thinking as a defense.

Leonard goes on to discuss the eternal girl who "clings to absolutized innocence, avoidance of responsibility, lack of decision making, avoiding commitment, the darling doll wanting desperately to be taken care of and the armored amazon who covers-over the eternal girl. The amazon's central desire is to control. Since she tends to see the man as weak and impotent, or is reacting against his irrational use of power, she seizes the power herself. Being in control makes things seem safe and secure. But along with that control may go an overdose of responsibility, duty and a feeling of exhaustion.

Leonard's description of the eternal girl and the armored amazon ego-states or parts of self, depict one individual who is at war within. This individual will then project her internal conflicts on the partner she chooses. This "war within" is a classic example of intrapsychic intimacy issues. Leonard's description depicts the ego states common to most women. The client with dissociative disorder would obviously have even greater exaggeration and rigidity of parts with little internal communication. A client with dissociative disorder has more encapsulated parts of self, frozen in traumatic experience and a concomitant sense of self-injury, defectiveness and badness than do most other women. The DID client presents with alters that encapsulate each of these themes. Their behavior is therefore considered by others as "borderline like" or "crazy", but in actuality, is highly rational and predictable once the trauma-organized system is understood. Common to the typical individual, as well as the dissociative disorder client and the DID client, is a core of defectiveness layered within a high achieving perfectionistic executive self. The result is an even more extreme sense of being an impostor, as is described by Leonard's self-revelation. Since so much energy is focused on internal struggles between the warring parts of self, little is left to genuinely cathect other parts of self and thereby establish genuine intimacy. Instead, the contradictory needs from the different parts of self, and core beliefs of each, result in chaotic conflicting urges as if illustrated in Table 3.

The result of such contradictory core beliefs is self-destructive, self-sabotaging behavior, often intensified by attempts to change the reactive distance established by the couple. If a marital or sex therapist attempts to facilitate closeness or sexual

TABLE 3

CONTRADICTORY COGNITIONS ABOUT INTIMACY

1. Others are dangerous, but we need to be intense and close.

2. I am anxious about safety, but I can't protect myself so why bother.

3. I can't trust my perceptions so I will believe people more powerful than me, but they all want to hurt me.

4. Others will disappoint me, but "she" will be different.

5. I am bad, destructive and evil, but I deserve someone who is good.

6. Everything that goes wrong is my fault, but everyone hurts me and I'm innocent.

7. Others are bad and uncaring, but he cares. If he knew me he couldn't care.

8. I am unable to care for others, but I do care for him.

9. If I get too close to you, I will lose me, but I'm so lonely and need to connect to you.

10. Being vulnerable always has negative results and is out of control.

11. I can't allow anyone to help me or I'll become dependent, but I can't do it alone.

12. I make bad things happen, but it's not my fault.

13. I am so defective that the only partner I deserve is one that no one else would want. I want him, but I don't like or respect him.

vulnerability, it destroys the equilibrium established within the couple's system regarding each of these beliefs, and can cause the relationship to self-destruct. For this reason, it is important to realize that relational and sexual therapy can indeed be very harmful to the couple, and sometimes, it is the absence of a sex life that actually keeps the couple functioning in a distant but congruent fashion. Therefore, it is advisable to facilitate a high degree of trauma resolution and integration of "warring" parts of self before attempting to facilitate interpsychic intimacy.

SECTION 6: COMPETING PARTS OF SELF AND SEXUALITY

The following represents a sample of the competing feelings about sexuality and intimacy of one female DID patient concerning her husband. We have found these feelings to be quite common among DID individuals:

> Joan - Giant Joan, what do you think of Bill?
>
> Giant Joan - He's the only one you let me fuck. I like to fuck but you won't let me. I want it to hurt. I want a lot of them all together getting me good. That's what I do best. You don't know about that stuff...(I respond)...
>
> I like to be fucked but I don't like him. I want to kick him in the dick, punch him in the face, chop him in the neck like karate. I'm big. I'm strong. I'm just as big as he is. I can show him. I'd love to beat him up. Pull his hair. Poke him in the eyes.Joan - Those are the same things you want to do to Dad...but Bill hasn't hurt us the way Dad did...
>
> Giant Joan - I'd like to beat him up because he won't let me do what I want. He always has to have his own way. And when you're with him, you always listen to him, not me. You let him rule you and I hate that. I want to rule you. I want to be boss, king, best.
>
> Joan - Whirlwind, what do you think of Bill?

Whirlwind - He makes you feel bad. I love that. When you cry I get to smash you, squash you, let you know how helpless and hopeless you are. I love it when you finally feel like dying. When you get so mad you want to get revenge or leave him, that's when I'm really happy because I know my time is coming soon. You can't be mad and strong forever. I love that...

I hate it that he always comes back. I like it when he pouts and holds a grudge for two weeks and won't talk to you. That really hurts your feelings. It makes my job great. I like him watching war, blood and fighting on TV. I like it when you guys fight about it. I hate it that he always asks permission during sex. Why doesn't he just take it and use it like a man. If you ask for it, then hurt them. it's no good. You're just supposed to do it. He's not strong enough to do it right. I don't like him saying he needs you. His hands are too soft and too clean. He's too polite and nice sometimes. I like it when he's mean to you. I'm glad he doesn't shave on the weekends now just to make you mad. He used to shave but now he hates you just like I do.

Joan - Healing Light, can you tell me how my parts feel about Bill?

Helper - the eight year old is just coming out for the first time now. A lot of her strong feelings are linked to that. She is raw right now. She's upset, changing quickly, hasn't gotten as much reality feedback as the others. She needs him. She will need a lot of work. She's confused by Bill. She didn't tell you how much she loves him. She only complained. Your eight year old is very young, needs tender care. She would be devastated without Bill. She is so disappointed about his hurts because he is so important to her. Don't underestimate the value of caretaking to a young child. It's everything to her. She may confuse Bill with Dad in some hurtful ways, but by the same token she needs him like she needed her dad. Bill is not as helpful as he could be, but no one is perfect. The end result is he loves you, he is committed to you, he knows you and he will not traumatize you with rape, murder, torture and threats. You can learn from him. You project a lot from Dad to Bill. Your biggest problem is you're too smart. You think too much. You

> explore too many variables. You worry too much. If you need to leave Bill you will know.
>
> She's scared of him, she shouldn't be with him. He won't hurt her - but she's scared. She needs control, safety, predictability and he is not any of those things. He feels threatened now because he doesn't know what kind of person she will be. He's afraid of losing her, he's scared because he realizes if he changes he has to look at himself and see his fear and pain. He's fragile - he feels her moving away, he's jealous and threatened. He needs her strength for himself - if she moves away and claims her power then she won't give it to him and he will feel weakened. Physically she's not in danger, but he will hurt her emotionally.

The child parts in this example consider the husband a parental figure and want to please him and to be held, but consider sex a violation or duty or minimally, a source of confusion. For them, sexuality is revictimizing. The angry adolescent parts (Joan and Whirlwind) connect the husband with the father and with all men. They fear and despise him, while at the same time they compete with him and identify with some of the negative aspects of his behavior. The executive parts realize that the husband is getting a lot of projections and displaced attributions, yet there is truth to the allegation that he is emotionally hurtful out of his own fears. The husband's fears may culminate in the client's needing to leave as her strength grows, but the helper counsels patience, balance and non-reactivity. The sexual parts that developed to "service" the father learned that seduction was the only way of getting any of their needs met and therefore believe their reason for existing is to service men.

With the many competing voices, and potential sexual encounters triggering switching, there is predictably ambivalence regarding sexual behavior and confusing messages delivered to the husband.

Both relational and sexual therapies require some degree of trauma resolution and consensus between the alters, and therefore are requisite during the latter stages of therapy. However, the dilemma is that the relationship and sexuality cannot be "placed on hold" for such potentially long periods of time.

One solution is to speed the process of psychotherapy by inpatient treatment. Another is to engage the spouse's support with brief couple counseling and spousal group psychotherapy as is suggested in Laura Bass's book Partners in Healing (1993), or for both individuals to engage in their recovery simultaneously. Finally, the couple can utilize other forms of demonstrativeness such as touching and verbal affection during abreactive phases of psychotherapy. None of these options is ideal, and our experience is that many relationships terminate unless the partner is extremely patient and tolerant.

SECTION 7: PHASES OF TREATMENT

Table 4 lists the phases of treatment used in the Masters and Johnson Sexual Trauma and Dissociative Disorders Program. Initially, the goal is to establish safety, consistency and trust sufficient to contain spontaneous switching, abreaction and out-of-control behavior. Once containment is established, efforts focus around enabling the client to reconstruct their past, examining intergenerational details of the family of origin and day-to-day specific severe acute trauma, as well as the context of the trauma in relation to chronic inescapable stress, benign and malignant neglect, boundary disturbance and destructive "shame-bound" family system rules (Fossum & Mason, 1986). During these first two phases of therapy, the partner needs to be encouraged to

TABLE 4

STEPS IN TREATMENT OF TRAUMA

1. Develop safety and trust.
2. Establish grounding and containment.
3. Establish control over out-of-control behavior.
4. Teach cognitive errors, affect modulation and life skills.
5. Establish relationship between injured and executive selves.
6. Allow injured self to "tell", reassociating affect, sensation and knowledge.
7. Permit the injured and adult selves to reprocess information with therapist assistance.
8. Encourage release of affect embedded in memory.
9. Encourage catharsis.
10. Encourage confrontation.
11. Encourage presentification (see page 60).
12. Facilitate greater integration.

present for an assessment in order to attain more accurate information about the presenting trauma survivor, as well as to provide the therapist an opportunity to assess the daily support, nurturance and stress that the survivor might encounter during the initial stages of therapy. More often than not, the spouse has an equivalent amount of trauma as the presenting client, and engaging the spouse in recovery in such cases is optimal. During the containment phase, the therapist needs to help the client solve "here and now" problems that will interfere with working on "the past". Therefore, if the spouse is verbally, physically or sexually abusive, this behavior must also be contained or the client will not be "safe" in the second reconstructive phase. The spouse is also provided support since they are often victimized by the issues engendered in the survivor's past that play out in repetitive ways, including flashbacks, projections and trauma-generated expectations of self and others. The healing process itself is difficult in that the numbing techniques, if all works well, give way to active experiencing. This necessary phase with its heightened intensity compared to the previous dissociation may give rise to concern on the part of the unprepared spouse/partner. In a sense they have to be prepared for the short-term reality that the client will "get worse before they get better", or at least seem to at times as the long-dissociated feelings emerge. Additionally, in terms of anticipatory guidance, our experience is that rarely can the survivor enjoy intercourse during the second reconstructive phase of treatment. As is noted in Wendy Maltz's (1992) text, The Sexual Healing Journey, there are many ways of being demonstrative and sexual without intercourse. The couple may require several sessions of sex therapy

to teach them the joys of sensuality. Also, the partner needs to be encouraged to utilize masturbation for sexual release.

Within the second phase of treatment, the individual is introduced to a variety of expressive therapies to release the affect embedded in past trauma. The individual is also actively encouraged to renegotiate the boundaries with the family of origin where prior boundaries have been dysfunctional or trauma-generating, to direct their anger at the source, to release the control the past has exerted over them - i.e., the trauma bond. Only after such release is the individual ready to commit the time and energy requisite for current relationships and a redefinition of sexuality. Because these elements are essential prerequisites, relational therapy is always one of the last phases of treatment. Trauma resolution therapies do not help the individual who has no frame of reference or basic skills for intimate relationships to suddenly "act reasonably". Therefore, we typically offer educational classes focused around acquisition of the basic skills needed for healthy human relationships. Sexual imagery that is trauma bonded, and then reinforced by subsequent learning, also requires directive behavioral therapies before initiating the last phase of treatment, sex therapy.

SECTION 8: TREATMENT OF HYPOSEXUALITY: INHIBITED SEXUAL DESIRE (ISD) AND SEXUAL AVERSION

The Therapeutic Format

A prevalent belief in the field of sex therapy is that when reversal of sexual dysfunction or dissatisfaction is impeded by immediate factors such as spectator roles or performance anxieties, brief psychotherapy is useful, but when more involved issues are identified such as intimacy disorders, early trauma and dissociative disorder, longer-

term psychodynamic psychotherapy is required. The Masters & Johnson Institute's position is that many of the more complex problems can be treated successfully within the traditional rapid treatment format. However, if there is a high degree of unresolved trauma, dissociation or lack of integration, individual psychotherapy may be necessary before beginning sex therapy. Like sexual dysfunctions, many disorders of sexual desire stem from basic misinformation, lack of experience or destructive relational transactions which can be effectively treated with the permission-giving and educational components of sex therapy. Even when deeper issues are involved, brief psychotherapy can produce a reversal of symptoms which, in some cases, facilitates the resolution of these underlying issues. Directive sex therapy and marital therapy is particularly well suited to a couple who have not had a developmental opportunity to learn the structural components of a healthy marital and sexual relationship.

We routinely see couples in which one partner has ISD. Typically the couple check into a hotel and isolate themselves from the daily demands of children and work, as well as from anchors to the past. They are then seen on a daily basis for 14 days, wherein they are encouraged to focus all their attention on the "relationship". Deep-seated roadblocks to the ISD partner's low level of sexual desire usually will manifest themselves or be catalyzed by therapeutic intervention. Controlled therapeutic situations allow the therapist to elevate the couple's skills at intimate interchange - including such skills as problem-solving, demonstrativeness, responsiveness to the other's needs, creativity in socializing, modes of dealing with long-term hostilities and ambivalence regarding closeness, vulnerability, trust and bonding. Each day in therapy is both

diagnostic and therapeutic because more information about the couple's interactive patterns continually unfolds.

If a couple manifests transactions which are destructive to feelings of intimacy and sexual desire, the therapist actively directs the couple to their mutually stated goals in several ways: (1) by confronting the transaction; (2) pointing out its potentially destructive consequences; (3) offering skills to improve the couple's interaction; (4) providing specific suggestions on ways and means to practice the new skills; and (5) requesting that they implement the "new way" in the next twenty-four hours.

When the therapist sees the couple daily, the partners usually are increasingly motivated by observing rapidly developing changes in their behavior. They feel increased self-efficacy, and enjoy the newly learned techniques of positive communicative interchange and the resulting affectionate feelings. In turn, this sense of relational well-being increases motivation for further improvement and fuels the process of behavioral alteration.

A variety of power and control issues often block a couple's sexual intimacy. The goal in short-term, time-limited therapy is to help each individual in a relationship to develop a sufficient degree of self-confidence. This increase in self-confidence lessens the chance that he or she will be threatened by his or her partner's change in acting and thinking or by the partner's becoming temporarily too close or distant. Whenever an individual in a relationship attempts to coerce or manipulate the other partner to act differently, resentment begins to build. Encouragement of self-differentiation while

ensuring that the other partner does not become threatened, allows sexual desire to manifest.

The therapeutic approach of Masters & Johnson Institute is to utilize "the relationship" as a vehicle for change in the individual. Once the couple feel that they are on the same team rather than opponents, accepted rather than judged, connected and cared for, enormous individual change is possible. The partners learn to do small things for each other to show they care and create a history of positive exchange. A give-to-get attitude is fostered, reversing the negative spirals. Individuals who have been extremely controlling because of their fear of rejection or abandonment look into the therapist's directive mirror, reexamine the trauma-based core beliefs and acknowledge their resultant destructive behavior and its undesirable consequences. Responding to the partner as if he or she was someone who hurt them in the past is labeled a "flashback", i.e., a variety of virtual typically unconscious reliving triggered automatically by present relational circumstances which recapitulate traumatic dynamics of early intimate bonds. Out-of-control emotions such as rage or terror are always a result of flashback, and require individual introspection and grounding rather than transference onto the partner. The members of the couple feel more secure as their positive interchange minimizes the risk that either partner will leave the relationship. These behavioral and attitudinal changes take the pressure off sexual interaction as the couple's only means to express love and affection as they open new avenues for intimate exchange.

It is common that one partner is threatened by the other's change. In a co-therapy model, each therapist establishes a degree of rapport with the same-sex client

to support him/her in adjusting to change. In a same sex couple, the co-therapy model is still the most useful one as it maximizes the ability of the therapy team to focus on each partner as well as "the relationship" as an entity in its own right. The single therapist needs to establish rapport with each client, while simultaneously encouraging exchange of "affect" between the couple, rather than a more traditional transferential relationship between the client and therapist.

The couple are taught how to recognize negative emotional states within themselves - boredom, fear, hurt - and then use these emotions as signals for creative action to support the relationship. This leads to learning self-responsibility and gives the individuals practice at not playing the role of victim nor blaming the partner for their unhappiness. Each partner discovers that they do not have to be victims of their negative feelings but can use these emotions as signals for creative behavioral change. It is this central concept that eventually provides the couple with the opportunity to enjoy increased levels of sexual desire. When the client feels fear, instead of withdrawing from sex as he or she would have previously, the client attempts to ask for what he or she needs to neutralize the fear, and then continue to lend him or herself to further closeness. One very common misconception is that sexual interest "just happens" when a person loves or cares for his or her partner. In other words, the person supposedly remains basically passive and is just "struck" by desire. This belief is closely related to the "love conquers all" and the "male is always ready" myth. The strategy in dispelling myths such as these revolves around teaching the concept of sex as a natural function.

Sensate Focus

When treating inhibited sexual desire or sexual aversion, the techniques of sensate focus and structured touching suggestions (Masters & Johnson, 1970) are the most effective means of eliciting factors which interfere with "natural" responsiveness. These techniques are a means of gradually introducing stimuli that are potentially anxiety-provoking while allowing the individual to maintain a sense of control. Sensate focus provides an opportunity for cognitive restructuring by encouraging individuals to be less goal oriented. Sensate focus also serves the function of increasing the focus of attention and the coding of cognitions with sensations, thus facilitating their experiencing of lower levels of stimulation. The latter is particularly useful with dissociative numbing and with clients who experience deficits of the opiod system.

When sexuality has been trauma-bonded, sensate focus becomes a tool for introducing sexual behavior within a context of safety, control and affection. Sensate focus will catalyze fears of intimacy, misconceptions regarding sexual behavior, fears of losing control, of becoming too vulnerable and losing oneself, fears that the partner will go faster than they are comfortable with or won't stop if they are overwhelmed, and so on. Once these interfering factors are identified in the context of the daily suggestions, directive psychotherapy can be utilized in an effort to neutralize the "roadblocks".

Male and female partners, regardless of whether they have been sexually abused or are the survivor's "partner", usually express concern about touching their partner's body in the "right" ways. Frequently, trying to please the partner sexually becomes an obsession, particularly for performance-oriented male partners. Frequently when one

partner obsesses about trying to please the other. both individuals admit feelings of ineptness and a sense of discomfort, performance anxieties about erections, lubrication, ejaculation and orgasm. For each partner, the rapid treatment format provides an opportunity to learn a great deal about their partner's sexual responsiveness in a non-demanding environment. In addition, he or she becomes more aware of his or her own sensual and affectional needs, and of the potential for sexual pleasure without intercourse or ejaculation. The couple begins to realize that pleasurable states of sexual excitement and sexual comfort can be attained with a partner. Each partner is instructed to focus more and more on the partner's body without "going away" into fantasy or fear. If one client has a specific phobia to some aspect of the partner's body, such as the genitals, the phobic partner may require several days of non-demanding genital touching with the partner before he or she is able to focus on the partner's body exclusively. This clinical adaptation to the sensate focus experience allows the client's "natural" responsiveness to unfold to tactile sensation and closeness to the dissociating partner.

Sensate focus is also useful for the partner of the identified patient who is a trauma survivor. The hypersexual "bypassing" partner begins to enjoy the experience of sensuality/sexuality without focus on release. while simultaneously learning new tools to manage stress and for problem-solving loneliness and affectional needs directly; that is, without sexual intercourse. The partner who is extremely dependent and obsessed with pleasing is encouraged to focus on pleasing him or herself in and out of the bedroom, and to communicate by recognizing their own needs first and requesting what

they want, hearing their partner and learning to negotiate in ways that will not engender later resentment.

Entitlement

In sex therapy, entitlement refers to the therapist giving the client permission to not be sexual. For example, a therapist might say: "it is understandable that given what happened to you and what you've done to yourself as a result of what was done to you, and the destructive influences on your choice of partner and the relationship you've each created, that you do not feel sexual. It would be a miracle or even dysfunctional if anyone could feel sexual under these circumstances!" Table 5 lists the conditions necessary for an individual to experience healthy sexual desire, arousal and ability to orgasm.

The goal of the sexual therapy is to help the couple create the conditions necessary to allow each to feel sexual. Up to now the hypo- or hyper-sexual symptoms have served the function of creating a necessary distance. It would be unethical and destructive to attempt to encourage intimacy and closeness without respecting the systemic functions of such distancing. Table 6 lists the requisite conditions for a couple to be sexual. Choosing an appropriate partner (i.e. one who is not a replication of the abuser) can be seen as a prerequisite to reversing sexual aversion. With a misogynist or misandrogynous partner. With these types of partners. it is reasonable to fear sexual closeness. Yet even in the context of a healthy, loving, committed relationship, partners of abuse survivors, before they are able to broaden their understanding of their partner's responses, may feel angry, rejected or shut out. Often both partners are tremendously

TABLE 5

CONDITIONS NECESSARY FOR AN INDIVIDUAL TO EXPERIENCE HEALTHY SEXUAL DESIRE, AROUSAL & RESPONSE

1. Resolution of family of origin trauma so the closeness with a partner does not create "flashbacks" of previously unresolved conflict.

2. Resolution of post-traumatic sexual traumas so the closeness does not activate terror, fear, numbness, dissociation, depersonalization, objectification of self or other or rage.

3. State of good physical health, without depression.

4. Sense of individual attractiveness and esteem.

5. Non-exhaustion.

6. The ability to say no, or some personal sense of empowerment, control.

7. The facility to feel excited rather than chronic apathy or boredom.

8. The capacity to be bonded without undue activation of fears of abandonment and enmeshment.

9. Comfort with perception of one's body and pleasure from one's body.

10. Attitude that pleasure in sexual interaction is natural and one's birthright.

TABLE 6

CONDITIONS REQUISITE FOR A COUPLE TO FEEL ENTITLED TO EXPERIENCE HEALTHY SEXUAL DESIRE, AROUSAL & RESPONSE

1. Physical and emotional attraction to partner.
2. The ability to feel sufficient control to say no and be listened to.
3. A degree of friendship.
4. The feeling of safety when being open and vulnerable: ability to leave their flanks open.
5. Feeling of connectedness and bonding.
6. Some level of commitment, such that neither is fearful of abandonment.
7. Establishment of some passion.
8. The ability to resolve conflict so that problems haven't accumulated that create resentment.
9. Need to feel free to represent what they want more of or less of without reprisal.
10. Sense of being on the same side with common goals and expectations.
11. The possibility of time to be intimate in and out of the bedroom, free of the stress and demands of modern life, particularly children.
12. Freedom to explore physical intimacy without a mandate to perform in a certain predetermined way.

confused and hurt, not understanding that what they are grappling with is not of either of their making. Understanding the pragmatics of PTSD, rape, flashbacks and trauma-engendered sexual aversion can remove the problems they have had from the realm of fault and blame and permit the couple to begin to work as a team to reverse these problems rather than feeling separated by them.

The first premise that the partner of a sexually aversive survivor must accept is that the survivor must be in control of how and how much. Creating maximum safety and alliance between partners is the quintessential element necessary. Any individual with sexual problems must be able to say "no" in order to say "yes". Particularly when bodily integrity has not historically been respected is it essential. Likewise, the partner cannot be expected to know in advance what will trigger flashbacks for the survivor - it may be something quite idiosyncratic to how he/she was originally abused. The survivor him or herself may not know until it happens that a particular touch, position or comment will evoke trauma-related fears or flashbacks. Therefore the couple need tools for efficient and effective communication. The survivor needs tools that can be utilized for staying in the present and getting re-grounded in the here-and-now when flashbacks or intrusive thoughts, images or feelings break through.

With each step of sensate focus, the therapist attempts to directively "hold up the mirror" to facilitate the structural changes that might allow natural affection and sensuality to unfold. The couple is given tools which are used to spend time together without conflict, to talk together and actively listen positively, to plan activities that are mutually enjoyable, to stop transactions that are destructive and to learn more respectful behavior.

When they begin to feel affection and closeness, there are high levels of fear that may then cause resistance to and sabotage of the therapy. Each level of fear is directly confronted and the client is helped to understand that their fears are based upon the past as "flashbacks" that do not necessarily apply to the present. They are then encouraged to interact differently, and to sample or tolerate the new level of reactive distance. The actual level of intimacy that can be tolerated or encouraged depends on the amount of damage and level of recovery of the individuals. Obviously, some couples discover in the process that they are not compatible with their partner because of differential recovery or poor initial bonding.

Different Appetites for Sexual Interaction: Tools for Sexual Communication

Sex as a natural function means that an individual's ability to function as a sexual being is congenitally established. Sexual functioning is in the same category as other natural biological functions such as respiratory, bowel or bladder activity. Erection, lubrication and desire develop spontaneously in healthy individuals. What makes sexual functioning appear different from other bodily functions is its exceptional capacity for voluntary control, thus making it more susceptible to developmental roadblocks. Sexual appetite is subject to psychosocial trauma, the influence of ill health and repression by antagonistic marital interaction. Sexual hunger can be acknowledged when present, but never forced on the partner if desire is absent. Instead, sexual interactions should always be negotiable since two people's sexual appetites are frequently not at the same level.

As a result of developmental and relational issues, one partner is often labeled as the inhibited one and the other the needy one, both emotionally and sexually. This cognitive process of labeling creates self-fulfilling prophecies. If a person with minimal desire continually forces him or herself, or is consistently pressured by a partner into sexual activity, sexual dysfunction or sexual aversion (a phobic reaction to sexual activity) may develop. In such cases, sexual behavior is not just unwanted, but instead, there is extreme fear and anxiety associated with anticipation of a partner initiating sexual interaction.

To resolve differences in levels of sexual appetite, individuals can "lend themselves" to determine if they are indeed sexually hungry or if they can "build" their appetite, instead of reacting with an uncompromising "yes" or "no". Encouraging the couple to enjoy touching, to appreciate low levels of excitement and to investigate other alternatives to intercourse also allows more compromise. The traumatized individual can relearn to appreciate sexual touch without terror.

If the sexual appetite of one partner is at a low ebb, too often the emotions of hurt, anger or rejection are evidenced by the other partner. When these emotions surface, most "low ebb" men and women force themselves into undesired sexual performance to relieve their partner's frustration. Once the couple accepts the concept of sex as a natural function, they are able to comfortably communicate changes in sexual desire as easily as their desires for food.

The hunger for food, for sex, for affection and for intimacy are all expressions of natural appetites which vary according to time, place and circumstance. To attempt to

control such natural appetites by rigid, arbitrary standards or by an imaginary concept of normality makes sexual interaction a performance. Culturally derived misconceptions (such as the belief that the male should always initiate sex), forces an individual to react or perform because of pressure from the partner's needs.

Analogous again to food, sexual appetite can be enhanced. Variety and creativity may be added to a couple's sexual interaction to prevent boredom or erosion of interest. Some individuals may need to have a partner's fantasy facilitated or playfulness encouraged in their approach to sexuality. These alternatives are never presented with emphasis on technique. Rather, they are introduced in the spirit of recreation, exploration, enjoyment and enhancement of intimacy. The couple is encouraged to try new options, understanding that the unfamiliar is uncomfortable and that as familiarity increases, comfort levels usually increase as well. As the couple's repertoire of sexual options increase, the initiation of sex is no longer equated with intercourse. Without that implied pressure, sexual feelings tend to unfold - naturally.

If needed, specific communicative skills are taught. Couples who have stopped exchanging important information are encouraged to talk about their life experience before they met, to get to know each other better. This usually breaks the habit of editing the expression of feelings. The partners also learn to ask directly for what they want and how to make requests without eliciting defensiveness or recalcitrance in the other partner. Other skills, taught as needed, are active listening, negotiation, creative problem solving, conflict management, assertiveness, social interaction, courtship techniques and play and time management.

This comprehensive therapeutic focus on the relationship for 14 days provides a powerful opportunity for alterations in the couple's previously unproductive patterns of interaction, and in distressing levels of ISD. Once positive changes occur, couples learn to maintain these changes by monitoring themselves objectively, If old habits manifest themselves, the partners usually can identify their destructive interaction, and discuss means of problem solving.

SECTION 9: TREATMENT OF HYPERSEXUALITY

The survivor of trauma is left with unmetabolized rage which is directed both internally and externally. Simultaneously, the traumatized individual is actively attempting to escape the emotions and the aloneness of their constricted, damaged state. Their sexuality awakens early, without direction, and is often intensely driving them to seek out partners. It is this highly ambivalent state which characterizes sexual compulsivity. Their vandalized love maps (which were previously discussed) are trauma-bonded and therefore predispose them to seek out destructive partners, transactions and sexual interactions.

Compulsive behavior is a means to numb-out when beginning to think and feel. This behavior also produces a high which allows the person to know she is still alive and human when feelings of depersonalization, numbness, emptiness and physical and emotional analgesia pervade. Compulsive sexual behavior becomes a solution - a means of feeling something in the dissociative fog, an experience of perceived control when feeling powerless, an illusory sense of safety, connection and temporary escape from the aloneness.

For the patient with dissociative disorder, the sexually compulsive part of self is typically quite separate from, and unintegrated with, the executive self that presents to the therapist. The result is that most survivors feel like impostors. There are sexually compulsive parts of self who may enjoy pain and actually arrange to be victimized. There may be parts who have introjected the values of the perpetrator and who then perpetrate others. Thus, while experiencing the horror of their own early trauma and the intense feelings of victimization, the survivor may have another part of self that is saying "how can you be angry at what they did when you have also hurt others", or "that's when you were a kid, but the sex you had at age 20 was proof that you are the bad one". Therefore, getting to know the sexually compulsive parts of the client is a requisite before too much abreactive trauma-resolution work is undertaken, since the embedded anger is likely to become self-directed. As many as one-third of the female clients we see who were sexually abused as children have told us that they have sexually touched children some time in their development. One woman writes:

> 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 on the 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 5

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 lay down." I said, "OK!" (I remember thinking - I was going to take a nap with my mommie!

We were laying 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 an 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 step-father. 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 a sickness in my stomach. I felt both shame and guilt - I don't know. I ran out. I got sick and went home. It has never been mentioned again.

Clearly, the client's reenactment of her early trauma needs to be understood contextually as "pathoneumonic of the syndrome". Reenactments are ritualized expressions of unresolved trauma, allowing the client to revisit the forgotten events in disguised forms,

and repeat with an attempt to complete or master that which is incomprehensible and unreconciled. A female survivor once described several repetitions including eventually having had her tubes tied at the age of twenty for fear of one day molesting her own child:

> As a child I would lock myself in the bathroom and play with dolls the way I had been touched. One would be in bed, the other would fondle him or her. I couldn't understand why I did this or where it came from. I was ashamed of this awareness, but couldn't help acing it out, I thought the shame belonged inside me, that the awareness was created solely from me.
>
> During teenage, I turned to boys to 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. My need for affection was so great, I couldn't say no to many people and I rarely did.
>
> Do you want to know why I had my tubes tied at age 18? Because whenever I thought of myself around my child, a mental image would always appear. The image was clear, and I believed in its certainty. I saw myself not being able to control the thing that lived in me from you. I saw myself fondling sexually my own infant!

This illustration poignantly conveys the developmental aspects of repetition and the unbounded fear which results from having internalized one's persecutor and of living out his or her legacy. The reenactment of trauma can additionally produce addictive highs, further perpetuating the sexually compulsive habit. Thus, the factors that maintain destructive behavior may become independent of the factors that originally caused them. Some functions of sexually addictive behavior are listed in Table 7. Seen in this context, compulsive sexual behavior serves as a clue or window into the original abuse, and

TABLE 7

FUNCTIONS OF SEXUALLY ADDICTIVE BEHAVIOR

Comfort/Nurturance

Numbing

Distraction

Sedation

Energizer

Attention - Cry for Help

Rebellion

Discharge Anger

Identity and Self-Esteem

Maintain Helplessness

Control and Power

Predictability and Structure

Establishment of Psychological Space

Reenactment of Abuse (Repetition/Compulsion)

Self-Punishment or Punishment of the Body

Containment of Fragmentation

Dissociation from Intrusive Thoughts, Feelings, Images

Cleanse or Purify the Self

Avoidance of Intimacy

Release Tension Built Up From Hypervigilance

Symptoms Prove "I Am Bad" Instead of Blaming Abusers

(Schwartz & Gay, 1994)

maintains survival in what feels like a situation of potential annihilation. Sexually compulsive behavior can be considered as a container for unmetabolized trauma, and the acting-out as "trance logical", that is always rational in the context of the cognitions that allowed the child to survive the early assault on his or her body and sexuality (Calof, 1993).

The DID client is an extreme example of the dissociative process characteristic of most PTSD survivors and most sexually compulsive clients. Typically the DID client will have introjections of their perpetrator presenting as alter personalities. An abused child can either identify with the aggressive, powerful perpetrator or the weak, passive, but usually equally angry partner. Living in a home with continual passive and active rage, the child is similar to a sponge. Rather than water, however, the child absorbs the high levels of resentment that flow between his or her caretakers. The child will tend to identify with the powerful aggressor, as if to say, "I'll become like him or her so no one can ever hurt me again." In addition, the child tends to rebel against internalization of the weak parent, whom they despise for not protecting them. The result is that thoughts and behavior similar to the perpetrator, whom they supposedly hate, develop. One survivor who was incested in infancy by her father, writes the following to her mother:

> And there is a big part of you in me now. I'm struggling to get rid of it, it is a lot like exorcising a demon - except that the you in me is like an implosion of blackness more than an explosion of rage. Oh yes, when your personality surfaces in me, I become punitive, paranoid, critical and blaming. All I feel is hate and fear. But when that passes, I'm left with a black hole, devoid of feeling. I'm empty, an emptiness that is palpable and painful. It's a blackness I can't describe. It is as if my knowledge and duplication of your horror is robbing me of who I really am. I, the real person, the person

> who's been lost for so long is missing. And sometimes it feels that if I can't rescue her soon from that void, she'll be lost forever.

In this quote the client is able to articulate powerfully the core of her self-hatred. She despises her mother and despises herself for internalizing and absorbing aspects of her mother.

While identifying with the powerful aggressor, the survivor may also show a tendency to act out the aggressor's verbalizations or behavior. Thus, the individual, or the alter or ego-state, may physically, verbally or sexually abuse children, even when the behaviors are not congruent with the beliefs or cognitions of the executive parts of self. The person everyone knows is not consistent with impulsive urges, behaviors and self-knowledge.

Controlling Reenactments

The first step in beginning to redress the harm done by childhood sexual abuse is to help the survivor gain control of any compulsive sexual behaviors or any sexual behaviors which recapitulate the dynamics of the original abusive sexual situation(s). As a hypothetical example: A man was abused for many years starting at age six by an older, bigger brother who would come into his bedroom, wordlessly subject him to sexual violations and then silently take his leave, satisfied and unconcerned with the younger brother's state. This younger brother now in manhood finds himself driven to gay bathhouses where men come into his room and one after another sexually penetrate him in silence and then leave. This example illustrates reenactment - an unconscious attempt to master early trauma by recreating the primary elements of the original abuse,

this time with an illusion of control, i.e. "I choose this". It is important to distinguish this behavior from mere experimentation with alternative forms of arousal. When it is trauma-based, the behavior has a driven quality. The individual feels impelled to perform it over and over. It is not a choice among many possible choices of arousing options but increasingly it becomes absorbing, exclusive and escalating. The level of risk for harm to self grows. Often the individual will experience a sense of depersonalization as the compulsive cycle commences. The DID individual may experience a switch in executive control or simply be aware that he cannot account for the past few hours. At the same time, however, the individual may notice soreness or injuries to the body for which he has no explanation.

In similar fashion, a woman raped as a young girl by her father or other significant males may enter into repetitive relationships with men who will treat her as an object and humiliate her. If the original relationship contained conflicting elements that could not be reconciled by the child she was (such as the father's tenderness turning to brutality), she may recapitulate the unmastered, unintegrated elements by choosing a husband who is kind and passive and then having an affair with a man who humiliates, objectifies and treats her with general disrespect. Again the key to understanding the behavior as reenactment is its driven, increasingly absorbing and clearly self-destructive quality. This type of behavior in the DID client would likely be a reflection of the prominence of different alter personalities creating different social relationships which satisfy distinct and contradictory needs.

To some extent the more clear-cut of these compulsive behavioral repetitions are treatable utilizing cognitive-behavioral, relapse prevention and 12 step models. However, as always, there must be motivation on the part of the client. With dissociative disorder clients, and particularly with DID clients, there must also be clarity and targeting - i.e. the part of self with the problem must be accessed and treated. Generic attempts at treatment will not have long-lasting impact due to amnesia barriers as many highly motivated DID clients having been through multiple treatments and treatment centers for eating disorder, chemical dependency and sexual compulsion/addiction can attest to. To produce lasting treatment change, two things are necessary. First, the appropriate part of self must commit to some recovery process with the system's support. Second, with all survivors who exhibit compulsive trauma-based behaviors, trauma resolution work around the original events being reenacted must be carried out. Without experiencing this second process, the dynamics of unsafety will continue to have a high likelihood for being recreated in subsequent relationships, either in partner choice or in the playing out of dysfunctional relational dynamics and/or compulsive sexual dynamics.

Utilizing Compulsive Sexual Behavior to Access Trauma

When an individual's sexual arousal is paraphiliac, violent, self-degrading or reflective of rage directed at oneself, one's gender or one's genital sexuality, the fantasy patterns of that individual can be directly reflective of the traumatic or stigmatizing events that have misdirected the unfolding of gender identity and sexual development. The deviant fantasies (of the host or alter or ego-state) can be abreacted and revivified under deep hypnotic trance (Glaser, 1993). The individual is oriented back to the past to scan

their memory for the origins of such deviation. Such assessing also allows for shame reduction since their deepest secrets are thereby made known to others, and the cause of such deviation is understood as an adaptation to early traumatic experience, rather than an indicator of "badness".

For example,a client discussed a recent shameful sexual liaison which resulted in his being urinated on consensually. The feelings of degradation were reexperienced under trance and then utilized to bridge him back to an age regressed state wherein he began to relive an incident that occurred when he was age six. Three school bullies beat him up and urinated on him. At this same age his older brother was habitually using him as a sexual outlet and peers were teasing him in other cruel ways. Repeated abreactions surrounding the trauma eventually resulted in a loss of desire for degrading sexual enactments and urophilia. Subsequent arousal reconditioning utilizing fantasy satiation (Abel et al., 1990) then resulted in permanent changes in sexual arousal patterns.

Often the sexually compulsive ego-state with pedophiles is childlike and reenacts specific sexual abuse that has occurred in or out of their childhood home. In most cases, the sexually compulsive ego-state is adolescent. Most perpetrators begin their activity in adolescence and deal with powerless, recalcitrant and passive rage by acting-out sexually. By accessing the teenage part of perpetrators and establishing a trusting relationship and rapport, the therapist can hear the multiple sources of frustration that plague the perpetrator. This enables the therapist to compassionately support and redirect the client's reactions to earlier mistreatment from abusive adults. The

perpetrator's adult parts of self are typically poorly differentiated and lack moral development. The therapist, therapy group or therapeutic community become the vehicle for facilitation of values clarification and the development of an effective, powerful adult self. This improved adult self is formed upon a commitment to honesty and integrity. The new adult self is eventually integrated with child and adolescent ego-states.

As the client is able to remember the early events, to express and reassociate the feelings and fears embedded in memories of the abuse and to correct the attached distortions in thinking, the trauma bond is broken.

In order to avoid relapse, the sexual compulsive must eventually learn to direct anger at the individuals who hurt him in a focused. nonviolent way, rather than to express uncontrolled, misdirected rage. Since the adults who modeled strong emotions during childhood for the client have typically been out-of-control, impulse driven, indiscriminant in their choice of targets and dangerous. the client needs to be taught that anger and other strong feelings need not equal violence, and to be given tools to enable safe release. "Old" anger toward the client's perpetrator can be resolved by giving the split off parts of self a voice to express strong emotions toward that perpetrator, typically utilizing hypnosis. Cory Hammond (1990) has called this process presentification. The therapist in initiating this process might say following an intense abreaction of early traumatic memory:

> And as you the adult together with your child walk forward, you can see your perpetrator against a white wall in front of you. He's unable to hurt you now. He simply has to stand there against the wall and listen. As you look at him there

> and think of how he hurt you, you realize you now have the words to tell him the things you couldn't then - what is it that you want to say to him?...that's right go ahead and tell him the things you couldn't back then...that's it, really tell him how much he hurt you...tell him about the pain...tell him how he's continued to effect your life, your relationships...do you want to continue to give him that power over you?...that's right tell him...

In this trance state, the individual is helped to have a powerful yet directed expression of strong emotions and thereby experiences a catharsis. The executive self and sexually compulsive self become partners in redressing the injury. Through the adult self's support and reclamation of the child self, the way is paved for ultimate integration, as the individual makes the connections which allow him to relinquish the trauma-driven behavior of the past and create a new cognitive schema of what the future could be beyond reenactment.

Arousal Reconditioning

Although trauma resolution is an important component in the treatment of sexual compulsivity, it is not the only component. Regardless of the quality of therapy involving trauma resolution, relapse is likely if the individual has low non-deviant sexual arousal. Following treatment which has resulted in (1) reduction of fear in close adult relationships, (2) improved social skills, (3) neutralization of rage and powerlessness from early abuse, (4) increased self-efficacy, (5) restructuring of core beliefs and cognitive distortions, and (6) trauma resolution and integration of split-off parts of self, the individual may experience ego-dystonic deviant sexual arousal. Fantasy satiation (Abel et al., 1990) or covert sensitization (Schwartz, 1992) can then be used to further facilitate changes in sexual arousal and fantasy patterns. Sexual therapy and sensate

focus are particularly useful at this phase of therapy to neutralize specific sexual phobias and encourage healthy sexuality.

Within DID, distinct ego-states which developed as a consequence of multiple traumas may each have different deviant sexual arousal patterns. For example, one DID client verbalized the following sexual arousal patterns by different alter personalities:

Adolescent Bob

I like rough sex with women using drugs, sometimes letting the women be in control, sometimes me treating them like bitches and whores. I would like to have sex with mom. She's in the next room, maybe she'll walk in on me when I'm masturbating. I like big women with big breasts, obese women, whores who like it hard and do whatever I tell them to do. I like anal sex with women from behind. I like sex with two girls at the same time or another man with my wife while I'm watching. I feel I'm inadequate about my sexual self with just one testicle. I hate my self/body. everything. I'm not worth living. I like to do it 5-6 times in one night. I don't like women for very long. I like to experiment.

Judy Adolescent

I'm a whore and slut. I like it hard till it hurts. I like to satisfy my man. I like it in my ass real hard till it bleeds. I like for you to beat the hell out of me while you're having sex with me. I'll give you oral sex too. I'll take on 4-5 men at one time. I'll do just about anything to satisfy my man. That's all I'm worth, your servant. I don't care about myself. I'm not lovable just a whore and a slut. I like it from behind too. Two men at one time. I'll suck your penis good and then stick it in my rectum. Do it to me hard from behind. It's the way I love it.

Janet Promiscuous Tricky

I'll take your nuts and cut them off. I hate men. I hate you. I'm like a Venus fly trap. Sweet on the outside, but deadly inside. You men are so stupid. I can get anything I want through sex. I'm a man-manipulator, conner, cunning. I love to castrate men and laugh at them afterwards. You helpless little bastards. you think through the head of your dick, give it to me you'll be sorry, I'll leave you wishing you had never met me. I'm your worst nightmare come true. You won't know it by my appearance but I'll love you then I'll stab you in the back.

Johnny 8-13

I'm a woman's boy. Except I'm looking for a new mamma. Mine won't have me. I'm always trying to get a mom to let me be her son but this involves sucking her breasts and her loving me and kissing me like I'm a baby. I need all mom's attention, there's not enough to go around. I want her to make me have sex with her, and control me and I'll be her love slave. I have confused feelings about a mom. ---I just want one. I just want to forget about all this shame and bad feelings and retreat to my mommy, but she's not there. She's gone somewhere else.

In such a case, arousal reconditioning is introduced to each ego state separately during hypnotic therapeutic sessions, following trauma resolution therapy.

SECTION 10: DISCUSSION

The understanding of post-traumatic stress, disorders of extreme stress and dissociative solutions also allows one to understand sexual and intimacy disorders. Until recently, the inability to comprehend the development of sexually compulsive symptomatology led to a symptom-based nosology and emphasis in treatment. This treatment emphasis was necessary, but insufficient. for large numbers of clients. Trauma-based treatment holds the promise of helping many others make substantial changes.

Clients with dissociative disorder present with a variety of hypo-, hyper- and asexuality syndromes with concomitant intimacy disorders. This paper provides a conceptual framework to strategize a myriad of therapeutic interventions.

Treatment of trauma optimally has three treatment phases. The first is establishing control of out of control behavior such as drinking, eating or sex. The second is trauma resolution, reassociation and the integration of dissociated parts of self.

The third phase consists of relearning the building blocks which comprise a capacity to establish and maintain healthy relationships, including sexuality.

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