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THE ROLE OF DISSOCIATION, AFFECT DYSREGULATION, AND DEVELOPMENTAL TRAUMA IN SEXUAL ADDICTION

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Abstract

The term addiction applies to a morbid form characterized by substance abuse, an object or a behavior; it defines a dysfunctional mental state characterized by a feeling of irrepressible desire and an uncontrollable need to repeat this behavior in a compulsive manner; it is an invasive condition marked by the phenomena of craving in a framework of uncontrollable habit that causes clinically significant distress. The author proposes a new interpretation of an sexual addiction as a dissociative mechanism to regulate non modulated emotions which were not mentalized (traumatic emotions) in early relationships with primary caregivers. To start from this theoretical model, this article suggests a treatment of sexual addiction focused on the identifying and regulation of traumatic emotions implicated in sexual compulsion.

Key words: sexual addiction, dissociation, psychoanalysis, affect dysregulation, mentalization, psychotherapy

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Introduction

The term addiction applies to a morbid form of a behavior defined by a dysfunctional mental state. Addiction is characterized by a feeling of irrepressible desire and uncontrollable need to repeat an act or behavior in a compulsive manner. Moreover, it is an invasive condition marked by the phenomena of craving and possession of an uncontrollable habit, which causes significant distress if not satisfied (Caretti and Craparo 2009). Thus, sexual addiction can be thought of as a specific type of behavioral addiction. Importantly, not all types of sexual behavior are classified as sexual addictions. According to Goodman (1998), the "key features that distinguish sexual addiction from other patterns of sexual behavior are: 1) the individual is not reliably able to control the sexual behavior, and 2) the sexual behavior has significant harmful consequences and continues despite these consequences" (p. 1).

From a psychoanalytical perspective, we must make a necessary distinction between neurotic sexual symptoms and addictive sexual behaviors. Neurotic sexual symptoms are "substitute formations" of unconscious conflicts (Freud 1895). In these cases, analytical interpretation is useful in order to bring such conflicts to the surface from the unconscious . Symptoms of a sexual neurosis are manifold, including shyness, stuttering, shame of nudity, frigidity, premature ejaculation, impotence, failure to achieve full orgasm and lack of sexual fulfillment. Clinical work with sexual addicts, however, has demonstrated that the psychoanalytical interpretation may not be accurate. For instance, Bromberg (2011) asserts that addictions are associated with un-symbolized dissociative experiences from early life (e.g., neglect, abuse). What remain of these experiences are traumatic memories, caused by traumatic caregiver-infant attachment. Thus, in these patients, addictive behaviors are related to traumatic memories. In accordance with this point of view, Caretti, Craparo and Schimmenti (2013) consider addictive behavior as a dissociative defense mechanism to modulate traumatic memories triggered by stressful events.

A developmental-relational perspective of sexual addiction

In the previous paragraphs, I sustain that the onset of sexual addiction results from pathological primary caregiver-infant relationships. Indeed, several researchers have observed that chronic relational traumatic experiences (e.g., emotional neglect) can lead to the structuring of unnameable and un-symbolized emotions residing in implicit memory that, when triggered by stressful conditions, arouses a state of disorientation, physiological hyperactivity and unexplainable pain. This distressed state leads the patient to implement sexual behavior of a dissociative nature. The reference to early trauma is, therefore, critical in the understanding of the etiopathogenesis of sexual addiction.

In particular, when caregivers lack emotional attunement to a child's needs, it can disrupt the development of a secure attachment bond between the caregiver and child and represents a traumatic experience for the infant. Allen (2008) described the lack of emotional attunement to the infant as a failure of *mentalization* on the part of the caregiver. We know that mentalization is "the skill that enables one to interpret others' minds, which developmentally precedes and then fosters the ability to read and understand one's own mental states. Although it might seem that mentalization and its operationalized form, reflective function, falls within the domain of cognition, on closer examination, this is not really the case. The attachment relationship is, after all, an affective bond. Secure attachment facilitates the capacity to regulate

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affects and, thus, presides over the movement from co-regulation to self-regulation. Initially, infants are dependent on caregivers to help them contain strong negative affects and to promote tolerance for positive affects. As their capacity for affect regulation develops in the second half of the first year of life, the sense of self emerges, which in turn renders a better capacity for regulation. Affect regulation relies on discerning the intentions of others and learning to see oneself as a being someone who has his or her own intentions; thus, it prepares the way for mentalization, which unfolds between the ages of 4 and 5. Mentalization, therefore, has an intrinsic relation to affects. Affect regulation is the basis for mentalization, but mentalization then fosters a new, more differentiated kind of affect and self-regulation, that is, affectivity (Jurist 2005, p. 427).

Jurist uses the term of affectivity to indicate the process that "immerses us in the exploration of how our affective experience is mediated by the representational world - in other words, how current (and future) affects are experienced through the lens of past experiences, both real and imagined. Affects might well occur in a pure, universal form without such mediation, but this is unlikely given the extent to which affects are connected to relationships with others […] Affectivity is based on interest in fathoming the meaning(s) of others' and especially one's own affective states. Affectivity requires a process of working through the manifestations of our representational world in current affective experience. In the broadest sense, affectivity aims to preserve and render intelligible the complexity of affective experience, insofar as it is possible to do so. This is a goal that is no less significant, evolutionarily speaking, than the goal of acting on one's emotions" (p. 428). Symbolization of emotions is primary condition for successive identification, modulation and communication of affectivity (process of mentalization). For this reason, we cannot mentalize a mental object which has not been symbolized.

The emotions which are non-symbolized and consequently not mentalized within a traumatic attachment will be experienced only on a pre-reflective mental level. We can define it as traumatic emotions (Craparo 2013).

We list below the characteristics of traumatic emotions, which are distinguished by their nature: a) non-symbolic, as they lack a mental representation which may define them; b) physiological motor, for the absence of reflective processes, their activations abruptly produce stereotypical, rigid and frequently out-of-control reactions; c) painful, due to their failure in identification and modulation, which produce an increase in the perceived intensity partly resulting from an unbearable hyperarousal; d) disorganization, because they activate mechanisms of disconnection among Self states as a response to stressful conditions experienced by the individual as a source of threat to his\her own identity.

In the sexually addicted, we can suppose that sexually addictive behaviors represent a retreat which is used to modulate traumatic emotions (often manifested as psychophysiological arousal) which surface during stressful situations. Moreover, according to this perspective, sexually addictive behaviors are not "substitute formations" of unconscious conflicts, but dissociative defenses against traumatic emotions resulting from early traumatic experiences, in an individual with a history of early traumatic experiences (developmental trauma) and deficit in mentalization. Indeed, several studies found significant correlations between deficits in mentalization, traumatic attachment, and dissociation in sex addicts.

Clinical vignette

Giuliano is a smart and clever 27-year-old man who suffers from problems related to sexuality. Although he lives a satisfying sex life with his girlfriend, he often surfs the Internet for several hours (4–5) a day looking for porn that always ends in masturbation. While standing in front of his screen, Giuliano feels he cannot control himself or his own will. It is clear from interviews that his urge for masturbation is enhanced by the pornographic images. These episodes are preceded by sudden, inexplicable, and intense states of physical tension that cause an overwhelming sense of somatopsychic pain.

The difficulty in understanding the nature of his arousal state and the inability to modulate the pain caused by intense anxiogenic experiences lead him to practise the only behavior that appears to be effective: masturbation. Masturbation restores his confidence, but it is always followed by a sense of guilt and shame. This state of tension is likely an unacknowledged and unknowledgeable emotional state that he is not able to mentalize.

The origin of Giuliano's deficits in mentalization are found in his non-secure family system (non-mentalization begets non-mentalization). His parents were a violent, alcoholic father and an entrapping, depressed mother who has never encouraged Giuliano to be autonomous. Indeed, it was typical for her to criticize and dishearten him (e.g., "What do you think you can do without your mother?"). The recurring traumatic experiences of paternal violence and emotional neglect filled him with a sense of inefficacy, unworthiness, and low level of self-esteem. This made it impossible for Giuliano to develop independent subjectivity. Thus, it seems that his sexual behaviors were related to traumatic infant-caregiver attachment.

Beyond his early traumatic experiences, Giuliano's mother suffered from post-partum depression (PPD) after his birth. This seems significant given previous research has linked PPD with ineffective parenting. For instance, Meins et al. (2011) reported that post-partum depression is related with mothers' inability to comment appropriately on their infants' cognitive abilities (or maternal mind-mindedness) beginning from the first year of life. Another research group showed that appropriate mind-related comments predicted secure infant–mother attachment and superior mentalizing abilities by age 2 (Laranjo et al. 2010) and in the preschool years (Meins et al. 2002, 2003). Thus, we can suppose that Giuliano's mother's PPD may have disrupted her interactions with him and created a psychological vulnerability for him.

For Judith and Allan Schore (2008): "The essential task of the first year of human life is the creation of a secure attachment bond of emotional communication between the infant and the primary caregiver. In order to enter into this communication, the mother must be psychobiologically attuned to the dynamic shifts in the infant's bodily-based internal states of central and autonomic arousal. During the affective communications embedded in mutual gaze episodes, the psychobiologically attuned, sensitive caregiver appraises nonverbal expressions of the infant's arousal and then regulates these affective states, both positive and negative. The attachment relationship mediates the dyadic regulation of emotion, wherein the mother (primary caregiver) co-regulates the infant's postnatally

developing central (CNS) and autonomic (ANS) nervous systems" (p. 11). Children learn to modulate their emotions into a mentalizing attachment with caregiver. Therefore, it seems plausible that traumatic emotions are a consequence of a lack in caregivers' attunement to what their child is experiencing beginning from the first year of life.

The case of Giuliano is a good example of the psychopathological effects caused by chronic traumatic experiences between children and their caregivers. For this patient, pornographic sites and masturbation represent a sexualized cover aimed at modulating painful emotional experiences stemming from his contrasting feelings of love and hatred towards his parents, as well as from hyperactive physiological states that are rooted in suppressed traumatic emotions.

Goldberg (1995) asserts that a specific sexualizing activity is often used to face feelings associated with a narcissistic scar, the failure to internalize a self-object. This defensive action is soon used to cope with negative feelings that are manifested in various situations; thus, the success of sexualization becomes the obliteration of the feeling itself. This way, all intense and potentially disturbing feelings may be regulated by using sexualization.

Indeed, sexualization, when interpreted as a psychic retreat of dissociative nature (Schimmenti and Caretti 2010, Steiner 1993), represents a form of self-medication for a body injured by memories of recurring traumatic experiences stored in the somatic memory (Craparo 2011). Such memories are the seat of emotional states, which were not originally symbolized and mentalized (traumatic emotions) in early infant-caregiver relationships and are related to painful feelings. The activation of these memories, and of their emotional states as a response to stressful internal or external triggers, provides the individual with unbearable and intense pain often accompanied by intolerable panic and sensations of anguish. Therefore, it seems important to understand the function of traumatic emotions in order to better understand the nature of sexual addiction.

Traumatic emotions: windows of tolerance

What we observe in a sexually addicted individual is his or her inability to recognize emotions as signals. In these individuals, what is typically affected is their capacity to tolerate the physiological arousal which follows the emergence of traumatic emotions. Ogden, Minton and Pain (2006) reported that traumatic experiences alter the tolerance threshold of sensorial stimuli and result in arousal states of traumatized individuals oscillating between hyperarousal, produced by the sympathetic nervous system, and hypoarousal as an activation of parasympathetic dorsal vagal complex. Excessive activity of the sympathetic system is associated with an increase of heart and breathing rates, as well as with a general sensation of tension. On the other hand, the activity of the parasympathetic system produces a dissociative disconnection characterized by a reduction of heart and breathing rates, a sense of numbness, and a general decline in mental activity. Recent neurobiological studies (Ogden et al. 2006) showed a close association between trauma, states of hyper- or hypoarousal, and a narrowing of the tolerance window of emotional functioning. More specifically, the tolerance window is the boundary within which "various intensity of emotional arousal may be processed without disrupting the functioning of the system" (Siegel 1999 p. 253).

The narrowing of the tolerance window and the recursive oscillation between the states of hyperarousal and hypoarousal may eventually hamper more complex cortical functions, which foster metacognitive processes of self-reflection and impulse control. Moreover, this process may cause a progressive fragmentation of the sense of self that generates disorientation, fragmentation, an increase of difficulty when modulating sensorimotor activation, and vulnerability to pain.

Vulnerability to pain in sex addicts is not a general condition that involves an experience of one's own individuality (as we may notice in psychosis); instead, it is related to a sensorimotor reaction that exceeds the boundaries of the tolerance window in response to the activation of traumatic emotions. Better put, a sex addict is vulnerable to the pain caused by somatic sensations associated with specific emotional contents that are experienced at certain times in his or her life.

Clinical vignette

When he comes for our session, Roberto, an eighteen-year-old teenager, reports his own inclination to regularly engage in (hetero-) sexual promiscuous experiences with girls he has never met before, and often with prostitutes. Such an urge, which has the features of impulsive-compulsive behavior, is caused by a state of tension that suddenly overcomes him without an external cause. When invited to describe the psychophysical state accompanying this tension, he claims to always feel an increase in heart rate, excitement (with erection), sweating, and severe pain in his stomach. Thus, he is experiencing hyperarousal.

His psychological state associated with this physiological arousal is characterized initially by confusion that is soon followed by a dissociated self-state. As affirmed by Roberto,

during those moments, "I feel like a different Roberto. I am grabbed by sexual fantasies that come with such strength that I can't get rid of them. I get the urge to stop the pain by going with prostitutes. I don't care about what will happen to me, or if I'm seen or about the embarrassment if my family found out. It's like I am someone else. I don't care a damn about anything or anyone. But, after having had sex with a prostitute, I feel bad. I come home and shut myself up in my room feeling sick and ashamed. You know, I can't even stand looking at myself in the mirror. I keep saying to myself that this is the last time, but it's just a lie."

The therapy sessions with Roberto show that his compulsive need to have sex does not represent the expression of an unconscious conflict, but a dissociative flight from traumatic emotions. That said, it is possible that neurotic symptoms co-exist with unrelated symptoms of unconscious conflicts in the same subject (Craparo 2013). Roberto's state of hyperarousal (which can be considered the basis of his craving) is thus the expression of emotions that he does not reflectively link to prior life experience. It is for this reason that he is led (the individual) to use an external object (sex); sex then, according to the patient's experience, is capable of reducing a state of psychophysical tension producing temporary pleasure. Indeed, abnormal emotional experience processing is related to his relationship history with non-responsive caregivers. Family anamnesis shows that Roberto lives in a neglectful family where he was taken care of by material means more than emotional means. An example of this emotional neglect is exemplified in

the fact that he and his parents have reversed roles in their relationship. "Since I was a little child", says Roberto, "I've always found myself in the situation of comforting my mother. I've always had to reassure her because my father was often away from home. I've always tried to hide my pain because I knew there would be no one to comfort me".

By creating a therapeutic space aimed at fostering a mentalizing attitude about sensorimotor arousal, Roberto was able to take a path that led him to develop agency skills in order to regulate his own somatic experiences and, as a consequence, his compulsive urge to have sex.

Some considerations on the treatment of sexual addiction

In this paper, we have considered the dissociative nature of sexual addiction. The association between dissociation, early trauma, deficit of mentalization and affect dysregulation is an important area of research. Mentalization is interpreted as "mind-mindedness," or a process "by which we come to understand that having a mind mediates our experience of the world via the representation of psychological states" (Liotti and Gumley 2008, p. 124). On the contrary, a mentalization deficit "hinders the capacity for affect regulation in both personal and interpersonal domains, as well as the capacity to reconsider unusual (dissociative) experiences in the light of common sense and other peoples' opinions" (*Ibidem* p. 125).

In sexual addiction, addictive behavior is a dissociative measure, which is aimed at the avoidance of feeling psycho-physical pain, provoked by the activation of emotions, which are known (pre-reflectively) to the individual, but not mentalized (Bollas 1987). The activation of these emotions then leads the individual to experience states of sensorimotor hyperactivity.

Thus, psychotherapy must help the patient to visualize and represent states of arousal exceeding his or her window of tolerance. In this reflective skill, the purpose is to manage emotional experiences and to integrate the capacity of sensorimotor, emotional and cognitive information. Therefore, we consider a mentalization-based treatment (MBT) as a suitable treatment for sexual addiction.

This type of treatment has been recommended as a treatment of Borderline Personality Disorder (Bateman and Fonagy 2004) and for post-traumatic syndromes (Craparo 2013; Craparo et al. 2013a, b; Gori et al. 2013; Giannini et al. 2011). The goals of mentalization-based treatment of sexual addiction are increasing mentalization, which entails: a) developing capacities for the identification and exploration of traumatic emotions, b) working on current painful mental states, and c) developing the ability to inhabit one's own body.

As previously mentioned, an aspect we consider essential, when it comes to handling sex drives, is the acquisition of a new relationship with pain. Importantly, we underscore the importance of helping the patient to mentalize his/her own pain. When patients are able to mentalize pain, they will develop a new relationship with both their own emotions and body. Thus, the therapist would be expected to encourage the patient to gain a new self-awareness to make him or her capable of linking an idea of the body to (painful) sensations he or she is experiencing in the present, or has already experienced in the past.

Conclusions

Our reflections on sexual addiction lead us not to consider compulsive sexual behavior as a symptom (a metaphor of an unconscious conflict), but to think of it as a deficit of both the integration skills of mental and corporeal experiences, as well as a difficulty with the mentalization of (traumatic) emotions. As Allen et al. (2008) remind us, mentalized affectivity does not mean taking a detached intellectual stance on one's emotion, but rather entails achieving clarity about emotional experience. This extends to not just thinking clearly, but also *feeling clearly*. Indeed, feeling clearly is necessary to live sexually not to sedate one's pain, but to foster intimate relationships and to discover one's subjectivity, as well as that of the others.

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