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THE DISSOCIATIVE NATURE OF SEXUAL ADDICTION
The role of traumatic emotions

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Abstract

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

Keywords: Sexual addiction, traumatic emotions, dissociation

1. Introduction

The term addiction applies to a morbid form characterized by substance abuse, an object or a behaviour; it defines a dysfunctional mental state characterized by a feeling of irrepressible desire and uncontrollable need to be repeated in a compulsive manner; it is an invasive condition marked by the phenomena of craving in a frame of uncontrollable habit that causes clinically significant distress (Caretti & Craparo, 2005; Caretti, Craparo & Schimmenti, 2010a, b). From an etiopathogenetic point of view, the onset of addiction refers to aspects of vulnerability arising from pathological primary caregiver-infant relationships. According to research developed in recent years (Caretti & Craparo 2005, 2008; Caretti, Craparo & Schimmenti, 2006; Caretti, Craparo & Schimmenti, 2010a, b, c), it was observed that chronically neglected emotional experiences can lead to the structuring of unnamable emotional contents (traumatic emotions; Craparo 2006; Caretti & Craparo, 2008) residing in implicit memory that, when triggered by stressful conditions, rouse a state of disorientation, physiological hyperactivity and unexplainable pain that lead the patient to implement compulsive behaviour the nature of which is dissociative.
In addictions (including sexual addiction), dissociation weakens the affect-regulation ability and fuels the impulsive-compulsive need to indulge in addictive behaviour as a means of reinstating a sensation of pleasure as well as reduce hyperactive states (Ogden, Minton & Pain, 2006). This precipitates in a feedback loop: the memory of pleasure (ego-syntonic) and the compulsive ritualization aimed at pain annihilation (ego-dystonic) act as a fuel for obsessive thoughts and fantasies of addictive experience reiteration; that is an irrepressible desire which produces the urge to

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take action again, despite the negative consequences that action may produce on mental and physical health (Caretti & Craparo, 2009). Thus, the impulsive-compulsive spectrum appears as the syndromic base condition of addiction in general, and of sexual addiction in particular, which is characterized by a pleasure-seeking appetite and an uncontainable urge to put something into practice; it is a visceral overwhelming "hunger" that disregards both the risk and its negative effects. Such a craving stands on obsessive, impulsive and compulsive factors (Caretti & Craparo, 2009) that induce the individual to experience his\her sexuality not as a symbolic function of the desiring fusion of bodies, but as a realization of the urge to put something into practice in order to contain those intense, non-modulated emotions that were not mentalized in early relationships with primary caregivers. The obsessive-impulsive-compulsive spectrum of craving in addiction is composed by these following factors:

1. *obsessiveness* a) recursive thoughts and images concerning the experiences of addiction or the ideas related to the addiction (e.g. excessive absorption in reliving past addiction experiences or in day-dreaming or in planning future experiences of addiction); b) the thoughts and the images related to the behaviour of addiction are egosyntonic and cause, at the same time, a generalized tension;
2. *impulsiveness* a) restlessness, anxiety, irritability or nervousness when it is not possible to put the addictive behaviour into effect; b) recurrent failure to withstand and to regulate the desires of addiction and the impulses to put the addictive behaviour into effect;
3. *compulsiveness* a) repetitive behaviour of addiction that the person feels forced to put into effect, also against his own will, despite the possible negative consequences, as a result of the recurrent fantasies regarding addictive behaviour and the deficit of impulse control; b) the compulsory behaviour or actions of addiction are directed to avoid or to prevent states of uneasiness or to relieve a dysphoric mood (e.g. feelings of impotence, irritability, inadequacy).

Emotional Neglect and Sexual Addiction

The reference to emotional neglect is critical to understand the etiology of sexual addiction and traumatic emotions that trigger addictive behaviour. As already described in ongoing research (Craparo, 2006; Caretti & Craparo, 2008, Craparo & Schimmenti, 2008), emotional neglect is the result of a relational framework characterized by the caregiver lack of emotional availability and affect attunement skill that impact child demand of secure attachment and nurturing. It is a specific configuration, of a potentially pathogenic nature, of relational framework which includes the child and his\her primary caregivers. Such a relational framework is characterized by the lack of emotional mirroring, thus the child's emotional needs are neglected due to parental requirements, conflicts, fears and projections. Emotional neglect includes an array of contributors such as parental relational disinterest or disengagement, a role reversal, a psychological dominant behaviour directed to the child altogether with a neglectful attitude towards his\her autonomy and environmental exploration.
Even when not manifestly abusing, these contributors may have a traumatic impact on the individual emotional development. The relational framework of emotional neglect is thus marked by the caregivers disregard of emotions both experienced and communicated by the child. The consequence of the parent's lack of emotional attunement to the child's emotional demands is a failure in his/her personality development, a vulnerable Ego and a disorganization of Self-States.

Clinical Case

Giuliano is a smart and clever 27 year old young man who suffers from a problem related to sexuality. Although living a satisfying sex life with his girlfriend, he often surfs the Internet for several hours (4-5) a day looking for porn sites, his research always ending in masturbation. While standing in front of his computer screen, Giuliano feels he cannot control himself or his own will. It is clear from the interviews that the urge for masturbation, enhanced by the vision of pornographic images, is preceded by sudden, inexplicable and intense states of physical tension that causes an overwhelming somato-psychic pain. The difficulty in understanding the nature of the arousal state and the inability to modulate the pain caused by intense anxiogenic experiences can lead the patient to put into practice the only behaviour that appears to be effective: masturbation. Masturbation restores his confidence, even if it is always followed by sense of guilt and shame both occurring in his refusal to look at his own reflection in the

mirror. This state of tension experienced by him is nothing but an unacknowledged and unknowledgeable emotional state which he is not able to mentalize.

The origin of such a deficit in mentalization is to be found in a non-secure family system featured by an absent, often drunk father and an entrapping, depressed mother who has never encouraged Giuliano's demand for autonomy; on the contrary, she has always criticized and disheartened him ("what do you think you can do without your mother?"). These recurring experiences of emotional neglect fuelled in the patient a sense of inefficacy, unworthiness and a low level of self-esteem leaving no possibility for a desiring and independent subjectivity to emerge. The case of Giuliano is a good example of the psychopathological effects caused by chronic experiences of emotional neglect. For this patient, pornographic sites and masturbation represent a sexualized cover aimed to modulate painful emotional contents stemming not only from contrasting desires of love and hatred towards his parents, but mainly from physiological states (of hyperactivity) the connotations of which are often not acknowledged as the expression of an emotional state.

As Goldberg (1995) claims, a specific sexualising activity is often used to face feelings associated with a narcissistic scar, the failure of a Self-Object. This defensive action soon becomes available to cope with feelings that are manifested in various situations, from that point on the success of sexualisation becomes the obliteration of the feeling itself. This way, all intense and potentially disturbing feelings may be regulated by using sexualisation. Sexualisation, meant as a psychic retreat of dissociative nature (Steiner1993) dissociative state, represents for the patient a form of self-medication for a body injured by reminiscences of recurring traumatic experiences stored in somatic memory; such memories are the seat of emotional states which were not originally symbolized in early infant-caregiver relationships and are strictly related to feelings of pain. 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. Traumatic emotions

The clinical observation of sexual addiction induces us to consider the role of the so-called traumatic emotions. As we already know, an emotion is the result of various, neurophysiological processes which are hierarchically and independently organized. Some of these emotions are pre-programmed and have been working since the first days of infant life (fear, anger, sadness or joy), while others are produced by the individual's psychosocial development. Indeed, traumatic emotions are characterized by a failure of their mentalization necessary to effectively identify and modulate affective states in early traumatic attachments in the relationship with caregivers. As claimed by Fonagy and Target (2008) in cases of trauma produced by caregivers, the attachment system and mentalizing abilities operate in an inverse relation.

The failure in cognitive representation of traumatic emotions produces a *désagrégation* of the Self that causes the individual to be particularly vulnerable to stress and prone to a maladaptive use of dissociation experienced as a defensive response towards those emotions which were originally not-symbolized due to insecure and poorly developed early relationships. Notably, rather than the event itself, a traumatic emotion is that emotion excluded from the processes circuit symbolization. In recurring experiences of emotional neglect, emotions are not provided with any mental quality.

As affirmed by Siegel (1999), appraisal and attribution of meaning to stimuli are specific functions of the mind related to emotional processes. The concept of flexibility of emotional responding perfectly depicts the attribution process of a value, positive or negative, to internal and external stimuli as an expression of an innate appraisal system gradually shaped by social experiences. Thus, the relational value of emotion and the role played by it in the developmental process are vital to the survival of the individual. The caregiver's attunement skill (Stern, 1985) towards affective demands of the child helps him/her in developing the ability to disambiguate the internal world from external reality; this skill helps the caregiver himself to emphatically respond to the child's stress. Thus, the child's sense of security will be strengthened and the progression of emotional states, positive and negative, will lead to the complete development of the Self's sense of continuity. The child's attunement to the caregiver's mind is critical for the maturation of neuronal centres that are essential for the development of mentalization (Fonagy & Target, 1997) and are involved in self- and hetero- emotional regulation (Beebe & Lachman, 2002), as well as in the development of social skills and autobiographical memory. It is precisely in the maturation of metacognitive skills that resides in the individual's ability to translate emotions into units of meaning (feelings), which, once identified, can be modulated and communicated within interpersonal relationships.

The failure of the attachment relationship, meant as an emotional relationship, can become an evolutionary factor of vulnerability of the Self because the individual is not capable of making emotions his\her guide for the body, the

objects of the mind and the interpersonal relationships. Emotional contents which are non-symbolized and non-mentalized within an insecure, emotionally neglectful, primary attachment relationship (Craparo & Schimmenti, 2008) will be experienced only on a pre-reflective mental level. On the basis of our clinical experiences we suppose that these emotions, which can be defined traumatic emotions (Craparo, 2006), are implicated in sexual addiction. We list below the characteristics of traumatic emotions, which are distinguished by their nature: a) not-symbolic, for they lack a corporeal representation which may define them; b) physiological motor, for in the absence of reflective processes, their activations abruptly produce stereotypical, rigid and usually out-of-control reactions; c) painful, due to their failure in identification and modulation which produce an increase of the perceived intensity partly resulting from an unbearable hyper arousal; 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.

Jurist (2005) suggested the concept of aporetic feelings when referring to shapeless, unnamable emotions perceived through a state of arousal which leads the individual to affirm feeling "excited", "nervous", "irritated". It is a psychophysical condition where the individual is not aware of what he/she is feeling because of the lacking of a mental representation of the perceived emotional state. In the ontogenesis of the individual, emotions described by Jurist represent the basic condition from which a range of more complex emotional states will be developed and, in association with specific psychic skills (such as mentalization), the individual's capacity to feel emotions while staying within the emotional state (Fonagy et al., 2002). Mentalization of emotions represents an unceasing appraisal of one's own feelings in relation to sensorial perceptions as well as to stimuli coming from the outside: mentalizing always recalls the relational dimension of emotions and thought. Identifying, modulating and expressing are the three domains of emotions which are mentalized (Allen, Fonagy & Bateman, 2008).

Down this evolutionary line, traumatic emotions are the result of a lacking mentalization of specific, basic or aporetic emotion, which remain inside somatic memory due to repeated experiences of emotional neglect. For what it concerns the three domains listed above (identifying, modulating and expressing emotions), clinical observation and research on addiction (including sexual addiction) highlighted a surprising fact: deficit of mentalization has more to do with lack of emotion identification than with lack of verbally expressed emotions (Caretti, Craparo & Schimmenti, 2010a, b, c). This condition inspired Caretti and Craparo (2008) to coin the concept of words without feelings, enunciations such as "I feel anxious", an expression which lacks a body representation of a declared emotional state (Damasio, 1994). While talking about his girlfriend, a young man affirms showing her tender feelings. When asked to describe this feeling from a sensorimotor, emotive and cognitive point of view, the patient affirms he cannot do it. It may often happen that such a statement held by the patient is simply a repetition of something he heard from other people.

Traumatic emotions, window of tolerance

What we observe in a sexually addicted individual is his/her inability to recognize emotions as signals. In these individuals, what is affected is the capacity to tolerate the physiological arousal which follows the emergence of traumatic emotions. For Ogden, Minton and Pain (2006), traumatic experiences alter the tolerance threshold of sensorial stimuli, thus arousal states of traumatized individuals oscillate between hyper arousal, produced by the sympathetic nervous system, and hypo arousal 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, while 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 (*ibidem*) showed a close association between trauma, states of hyper- or hypo arousal and a narrowing of the tolerance window (Siegel, 1999), that is those boundaries within which "various intensity of emotional arousal may be processed without disrupting the functioning of the system" (p. 253).

The narrowing of the tolerance window and the recursive oscillation between the states of hyper arousal and hypo arousal, may eventually hamper more complex cortical functions which foster metacognitive processes of self-reflection and impulse control, as well as causing a progressive fragmentation of the sense of Self that generates disorientation, fragmentation, an increase of difficulty when modulating sensorimotor activation (Ogden, Minton & Pain, 2006) and an important 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), it is related to a sensorimotor reaction that exceeds tolerance window boundaries as a response to internal or external inputs that cause the activation of traumatic emotions: in short, a sex addict is

vulnerable to the pain caused by somatic sensations associated with specific emotional contents that are experienced at certain times in her\his life. In a recent research on rats, Sacco and Sacchetti (2010) found that during an emotional experience, sensory stimuli accompanying it (smells, sounds and colours) are associated with the emotion experienced at that moment. These researchers observed that painful emotional contents experienced in the past are stored in the secondary auditory, visual and olfactory cortex (also known as "higher order" sensory cortices). Notably, the activity of these areas is intensified by those sensory stimuli previously associated to painful events. On the other hand, no variation of the areas is present when those sensory stimuli have never been associated in the past to significant events from an emotional point of view. If research on humans confirms this finding, they will validate what we advocate about the role of traumatic emotions and their disorganizing effects.

Considering what we affirm in this article, psychotherapeutic intervention must help the patient to identify and modulate the emotional arousal, of both hyper- and hypo arousal, so as these reactions can retreat within the boundaries of the tolerance window.

Clinical Case

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 behaviour, is caused by a state of tension that suddenly overcomes him without an external cause. When invited to describe the psycho-physical state accompanying this tension, the patient claims to always feel an increase of heart rate, excitement (with erection), sweating and severe pain in the stomach (thus, it is a hyper arousal).

His psychological state associated with such physiological arousal is characterized by initial confusion that is soon followed by the emergence of a dissociated Self state. As affirmed by the patient: “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”.

Therapy of this patient shows that his compulsive need to have sex does not represent the expression of an unconscious conflict; it is a deficit of mentalization of traumatic emotions. His state of hyper arousal (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 they he is lead (the individual) to use an external object drug (sex) which according to the patient’s experience, is able to reduce psychophysical tension state (a state of hypo arousal) producing temporary pleasure. Abnormal emotional experience processing is related to the history of his relationship with non-responsive caregivers. Family anamnesis shows that Roberto lives in a neglecting family context where he was taken care of more from a material point of view than from an emotional one. An example of this emotional neglect can be considered the fact that he has always experienced a role reversal condition in his relationship with his parents. “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”.

Creating a therapeutic space aimed to foster a mentalizing attitude about sensorimotor arousal allowed Roberto 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.

Treatment of sexual addiction

According to what we stated so far, the treatment of a patient affected by sexual addiction requires specific clinic work aimed at the mentalization and the integration of the patient's own traumatic emotions. Affect mentalization (Jurist, 2008) represents the basic condition for the patient to be able to understand and regulate emotional contents (traumatic emotions) which lie beneath his sexual compulsion. In sexual addiction psychopathology, sexual behaviour is but a dissociative measure which aims to avoid feeling psycho-physical pain provoked by the activation of emotions which are known (pre-reflectively) to the individual but not mentalized (Bollas, 1987) and that lead him\her to experience states of sensorimotor hyperactivity.

Thus, psychotherapy must help the patient to visualize and represent states of arousal exceeding his/her window of tolerance (Ogden, Minton & Pain, 2006; Siegel, 1999). In this reflexive skill developmental process the purpose of

which is to manage emotional experiences and to integrate the capacity of sensorimotor, emotional and cognitive information, we consider a mentalization-based treatment (MBT) as recommended by Bateman and Fonagy (2004) for the treatment of Borderline Personality Disorder, and Caretti, Craparo, Schimmenti regarding post-traumatic syndromes.

The goals of mentalization-based treatment of sexual addiction are: a) increasing mentalization, which entails to b) developing capacities for the identification and exploration of traumatic emotions; c) working on current painful mental states; d) developing the ability to inhabit one's own body. As we mentioned in the previous section, an aspect we consider essential, when it comes to handling sex drives, concerns the acquisition of a new relationship with pain: notably, it refers to helping the patient to mentalize his/her own pain. Mentalization of pain goes through a new relationship with both one's own emotions and body. Thus, the therapist would be expected to encourage the patient to gain a new self-awareness so as to make him/her capable of linking an idea of body to (painful) sensations he/she is experiencing in the present or has already experienced in the past and that are the core of his/her pathological relationship with sexuality.

Conclusions

Our reflections on sexual addiction lead us not to consider compulsive sexual behaviour as a symptom, a metaphor of an unconscious conflict, but to think of it as a deficit of both: integration skills of mental and corporeal experiences and mentalization of the emotions. As Allen, Fonagy and Bateman (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 [...] not just thinking clearly but also feeling clearly. Feeling clearly indeed is a necessary condition in order to live sexuality not as a mental refuge where to sedate one's pain, but as a spur capable of driving the individual towards an intimate relationship where to discover one's subjectivity as well as that of the others.

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