Assessing Intra psychic Blocks to Sexual Pleasure Using the Milestones of Sexual Development Model

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Introduction

The men and women who come to us for help are profoundly vulnerable. They feel broken, unable to enjoy the basic human pleasure of being sexual. Clinically, cases which first appear to be simple dysfunction may later reveal extensive defects in sexual development. The focus of this article is on deeply troubled men and women with intrapsychic obstacles to intimacy stemming from family-of-origin issues.

Some of our most blocked patients experienced sexual abuse, and appropriately staged treatment for them is well defined (Maltz, 2001). However, perhaps two thirds of them were not sexually abused, yet standard behavioral exercises are too advanced and inappropriate for them. How can we identify and help these clients, whose sexuality never developed normally or whose sexual identity never evolved?

Sexual Difficulties are Normal Consequence of Non-Sexual Traumatic Experiences in Childhood

What does it take for a child to grow into an adult who is able to be psychologically and sexually intimate with the same person? What creates the urge to merge emotionally, and also the permission and ability to choose to lose control with our partner and experience deep, sexual pleasure in our body? Clearly, sexual trauma in childhood must not have occurred. But many kinds of families inflict "sexual trauma" in a more diffuse way, affecting the platform upon which the child's healthy sexuality needs to be built.

Our sexuality is formed by subtle and not so subtle lessons we learned in our family of origin. Consistent, good experiences with loving touch, eye contact, trust, empathy, positively-constructed body image, self esteem, and power are necessary building blocks. These "Milestone" experiences link feelings of being loved and feeling "good enough" with other developmentally crucial abilities and associations, for instance, with:(1) embodied feelings of pleasure, including (appropriate) familiarity

with the sights, touches, tastes, and smells of bodily intimacy;(2)the ability to tolerate feelings, one's own and others' (3) emotional closeness to another (4) relaxation, trust, safety, and energy flow; (5) the expression of feelings, and (6) ultimately with the free expression of sexuality. Without these good associations, letting go and turning one's body over to sexual experience with a beloved other creates anxiety, not arousal. If these tasks were not mastered, giving clients "permission" to be sexual and assigning standard sexual homework is premature at best and frustrating and doomed to failure at worst.

True, sex is bio-psychosocial, and multifactorial, and sexual problems can be relationship based. But usually, our patients with intractable primary problems were harmed by their upbringing. (Scharff, 1982). In some cases of lack of development or dis-integration, undiagnosed hormonal problems may have been combined with family patterns which were subtly or overtly inhospitable to sexual development.

Patients with deep-seated problems with sexuality and intimacy, particularly those who did not experience overt sexual trauma, cannot understand the root causes of their fear and conflict. They feel impaired, abnormal, beyond help. Because they cannot conceptualize what happened to them as being related to their sexuality, they are hampered in changing their feelings and their sexual functioning. Medical and mental health providers who are presented with patients who have deep sexual blocks might presume a non-existent history of sexual abuse as well ("You MUST have been sexually abused"), further upsetting and demoralizing clients.

What follows is a review of several crucially important Milestones in the development of healthy sexuality. Special attention is paid to issues experienced by victims of non-sexual trauma and neglect.

A model (Zoldbrod,1998) of fourteen Milestones in Sexual Development is useful to clients in explaining how certain non-sexual, negative family experiences are related to sexual feelings. Understanding the "why" of what went wrong, they feel less abnormal. Clients can identify areas in which they are blocked and the negative cognitions related to these blocks. This helps clients to be both more realistic about a timetable for change and more optimistic about the possibility of change. The therapist will find that the process of looking closely at individual pathways to sexual development aids in evaluating patients and in structuring and staging healing interventions. The earlier the developmental breach occurred, the less appropriate would be early use of standard behavioral sex therapy interventions.

Thinking About Three Groups of Families:

■Nurturing, Affectionate, Stable and Appropriate Families,

■Operationally Competent and Responsible, but Unaffectionate, Unempathic or Over controlling Families

■Highly Unstable, Clearly Damaging Families

It is helpful to think of families as falling into three groups.

* Group One: Had warm, affectionate, empathic, trustworthy, well-balanced, often harmoniously-intertwined parents. Clients' human, inborn potential to enjoy their sexuality and sensuality is intact. They may have sexual problems, but are in basic ways, unscathed. They have positive associations to touch, trust others, expect to be loved , accepted, and treated empathically. They have the capacity to be unambivalent about engaging in emotionally intimate relationships. They can untangle troubled relationships and learn new sexual behaviors with our help. Many times, they thrive in standard sex therapy.

* Group Two: Parents (or single parent) "balanced " and "responsible" but unaffectionate or not adequately empathic. May be emotionally cold, critical, or emotionally over controlling. Adults from Group Two suffer with sexual issues complicated by lack of good experiences with touch, empathy, trust, gender or power. However parents may be seen as responsible and family as normal. Careful assessment of early issues with touch, trust, empathy, self esteem, body image and power is important in planning appropriate treatment.

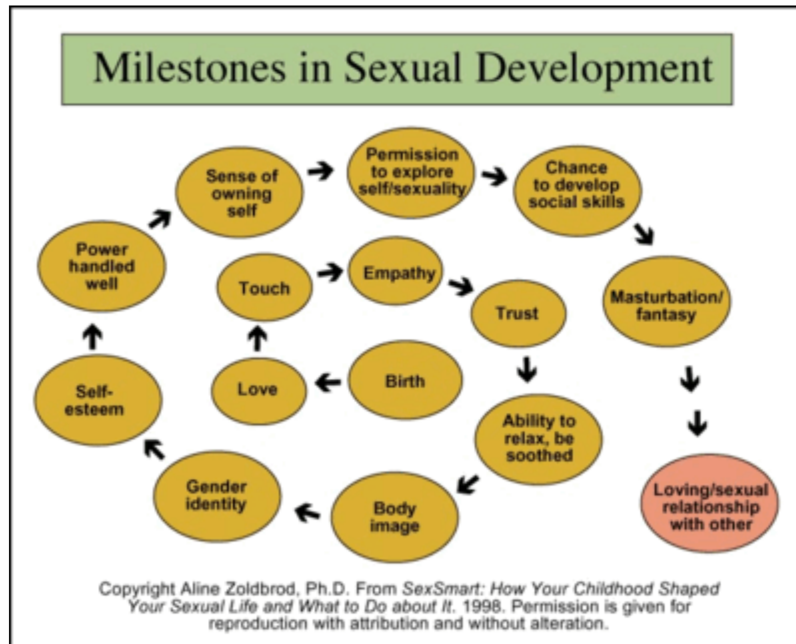
*Group Three: Unstable, damaging parents. Clients here grew up in families where parent(s) were mentally ill, unstable, violent, alcoholic, or abused drugs. In these families neglect, physical, emotional, or sexual abuse occurred, either to our patient, or to other members of the client's family. This group suffered trauma which created sexual sequellae. Experiencing, or even witnessing, any of these "non-sexual" kinds of abuse and neglect impacts adult assumptions about the safety of relationships, and about life, itself. It negatively affects the wish and willingness to be sexual (Levine, l988), or sexual with another, real, person, and can eclipse sexual drive in patients who are physically quite normal, and/or have coupled with a loving partner.

However, at best, only those victimized by actual sexual trauma believe that it is reasonable for them to have sexual problems. Adults from Group Three need to have in-depth assessment and the necessary rehabilitation in the areas of touch, safety, empathy, trust, self esteem, body image, gender and power before traditional sexual therapy is begun. Sexual problems may include the full range of sexual dysfunctions, sexual avoidance, sexual pain, sexual compulsions, and paraphilias.

Screening for Negative Family of Origin Experiences

Identifying oneself as a victim is painful. Denial and minimization is so great that no matter how carefully one screens clients for individual, family-of-origin issues affecting sexuality unless you give a special instrument to screen for subtle or detailed instances of chaotic unpredictability, neglect

(physical, medical or emotional) or abuse, (see Ratner, excerpted in Zoldbrod, l998), patients frequently maintain that their family experience was “happy” or “normal”.



Touch

Touch is a primary building block of sexual desire and sexual motivation, the “ground zero” of sexuality. Comfort with the touches, looks, sights, smells and sounds of intimate contact is learned in the family of origin. I estimate that possibly as many as half of our patients have some difficulty experiencing touch as normal, relaxing, comfortable, and pleasurable with a loved partner. When working with men, problem issues with touch may be hidden until midlife, when testosterone levels are lowered and raw, physical drive no longer powers sexual expression.

Only at that point, when arousal needs to be fueled with touch and intimacy, do some men realize that touch feels strange, tickles, or feels numb. (While Viagra can short-circuit this telling symptom, relearning touch would be a more appropriate and long lasting solution.)

Assessing Touch

A detailed assessment of each client's experience with touch is important in the evaluation stage of sex therapy. It is not safe to assume a positive association to touch without gathering specific data. Two assessment/treatment techniques (Zoldbrod, l998) are (1) drawing, annotating, and dating a Body Map (2)giving the patient a list of word associations to touch.

The dated Body Map is an outlined body (front and back) which the client colors in, using a code to indicate whether touch in that area is experienced as pleasurable, noxious, or variable in the present. (I usually use green for "go", red for "stop "or "no", and blue for "maybe".) Partners should exchange body maps and take time in therapy to explain the color code and the reasons for any "off-limits" and "maybe" areas to each other and to the therapist. Annotating the map is useful in helping partners remember what kinds of touches are welcome and which are problematical and why. In cases of illness or trauma, drawing " before and after" body maps are extremely powerful. Many times, the body maps reveal that clients are being touched in ways that are unwelcome or feel unsafe.

Clients from Group Three typically have body maps with a lot of red and blue and not much green. Progressive touch exercises which focus on touching only the green and getting permission to work on the blue areas are helpful (Zoldbrod, 1998).

It is not only clients from Group Three who have problems with touch. Some patients who color their maps with much green actually don't enjoy touch very much. Patients in Group Two often experience touch as "not normal" and not associated with pleasure. A lack of good associations to touch is not a neutral finding, it is a negative finding. Using a word association test, other strange or negative associations to touch are revealed and can be worked through.

Empathy and Trust

Trusting others to love us, to be reliable, and to have empathy for our feelings is a primary intrasychic sexual motivator and a major building block of sexual desire. (Levine, 1988).

Infants and children are helpless. Good parenting involves the parent(s) accurately assessing the child's feelings and needs without assistance from the child.

Sexual feelings are intense body feelings. Researchers at the Stone Center at Wellesley College (Jordan, 1991) have defined empathy as a process whereby a person (ie, the parent) allows themselves to feel in their body the feelings another person (ie the child) is feeling, while at the same time, knowing that it is the other person's feelings they are feeling. A child growing up receiving consistent parental empathy learns many positive, complicated lessons which create the ability to enjoy sexual pleasure within an intimate relationship. First, having receiving empathy, the child will go on to expect to be cared for and understood by others. Secondly, when a parent can tolerate the child's difficult or extreme feelings, the child then learns to tolerate the full variety of his or her intense feelings. (Without the ability to tolerate strong feelings in one's body, the adult will not be able to maintain erotic focus.) Thirdly, a child who receives empathy for a wide range of emotions will then have the foundation for interpersonal closeness. By definition, one can only have empathy for those feelings in another that one can tolerate experiencing in one's own body. The child who received empathy will be able to be empathic to others.

Feeling Good About Your Body (Body Image)

Body maps determine the ability to experience pleasure. Body image mediates sexual behavior (Fisher, 1986). Adults who grew up with parents who were affectionate and who praised them for their physical exploits and competencies or attractive physical aspects grow up to have relatively positive body images. (Women from societies with oppressive, restrictive notions of female attractiveness are affected by cultural standards, but those who had excellent parenting may be less vulnerable to unreasonable pressures for physical perfection.)

Clients from Group Two have body image problems which come from a lack of parental praise, lack of positive construction of a good body image through joint physical activities, or lack of affection. The “"metamessage” that comes from not being affectionately touched is that one's body is not adorable or treasured and that no normal person would want to touch you. Feelings of body insecurity in turn create social anxiety about one's attractiveness and can contribute to difficulty in maintaining one's erotic focus in adulthood when a partner is found.

Clients from Group Three have profound disturbances in body image. Parents who tease you about your looks, neglect your physical or medical needs, don't treat your body lovingly, or hit you create a distorted body map, and feelings of body despair or body worthlessness. Medical neglect (for example,

untreated skin problems, wandering eye, endometriosis) creates physical problems in adulthood which affect bodily health and functioning, the person's appearance, body image, and self esteem in general.(Zoldbrod, 1998). Growing up as the witness to the physical abuse of a parent or another sib demolishes body image almost as severely as being physically abused oneself, by virtue of corrupting the safety of body boundaries (Zoldbrod, 1998).

Unlike most of the primary milestones of sexual development, unfortunately, a good body image can be fragile. Illness, surgery, aging, or infertility can result in a body image damaged in adulthood. Changes in body image during adulthood can be assessed with the Double Onion technique (Zoldbrod, l993).

Power and Control

Parents have authority over children and can wield it benignly or malevolently, or somewhere in-between. Clients do not connect past experiences with power to their sexuality. Commonly, clients assume that the power and control patterns which were operant in their families are "normal" and will be repeated in any intimate relationship. Group Two clients whose parents were over controlling are ambivalent about getting into emotionally-dependent relationships, an ambivalence which may over time appear symptomatically as difficulty with desire, arousal, or orgasm. Clients from Group Three who overcome their ambivalence and enter into intimate relationships become obsessed with the power and control aspects of the relationship and hyper-vigilant about losing control to another person, creating the full spectrum of sexual problems, including pain disorders, desire disorders. sexual aversion, sexual compulsions, and paraphilias, or a dependence on scripted power and control relationships.

Permission to Explore Self and Sexuality

Research has shown that experiencing "negative familial and cultural attitudes toward sex" does not create adults who have problematical sexual functioning (Heiman et al, 1986). Ironically, if all of the preceding Milestones of Sexual Development went well in the patients' family of origin, patients have learned enough good lessons about touch, love, empathy, trust, power, relationship, and their own self worth to give themselves permission. Patients from truly nurturing, competent, physically warm families can make use of educational materials, books, friendships, and psychotherapy and sex therapy. Simply giving permission before the client has shown mastery of the earlier Milestones is not effective. And a lack of permission in early life can be remediated a lot more easily than problems with touch , trust, empathy, or power.

How Many Clients Have These Problems? Data on Prevalence of Unstable, Damaging Families in the United States

Families with many different problems harm a child's developing sexuality. Statistics are available for certain groups of problem families, but totally unavailable for others. (For example, total lack of physical affection between family members is seen as quite normal in certain cultures and families, so no statistics are collected on this phenomenon.) Here are some of the groups for which we have statistics.

Spousal Abuse/ Violence

There are no research studies documenting the high prevalence of sexual problems in adults witnessing wife-battering, but this has been my clinical observation (Zoldbrod,1998). Each year, about l0-15% of U.S. women, approximately two million women, are physically abused by their intimate partners (Tjaden and Thoennes, l998; Straus and Gelles, 1990. While separate statistics on emotional abuse experienced by battered women are not available, the extent of the problem has been noted (Sackett and Saunders, 1999.)

Zoldbrod (1998) offers a chart detailing the many sexual sequellae for the child witness of family violence. Most striking are disturbances in the body map, including numbing and ticklish sensations, changed body boundaries, and inability to experience relaxation, and a generalized inability to feel pleasure when being touched sensually. Additional problems are "pseudo-sexuality" with an emphasis on performance, anxiety, PTSD symptoms, poor socialization, over concern with power and powerlessness, and gender conflict. Distorted, highly negative cognitions about male-female relationships are common as well.

Female children of battered mothers do not want to identify with their victimized mothers. Male children can suffer from erectile dysfunction, premature ejaculation, and lack of desire stemming from conflicted feelings about being powerful or assertive in a sexual relationship with a woman. Guilt over not being able to protect one's mother can affect willingness to become intimate with a partner. Men and women have unresolved feelings of anger at the mother for not being able to take care of herself and them and disgust at her for continuing to be sexual with a battering partner.

Alcoholism

In the United States, alcoholism cuts across all boundaries-race, economics, gender, and nationality . According to the U.S. Department of Health and Human Services' National Institute on

Alcoholism Abuse and Alcoholism's statistics (2002), nearly l4 million Americans, one in every thirteen adults, abuse alcohol or are alcoholic. Sexias and Youcha (1985) estimated that there are at least 22 million adults in America who lived with an alcoholic parent (ACOA's).

There is a literature which loosely ties the dynamics of alcoholic homes to adult sexual and intimacy problems, primarily citing trust issues. (Sexias and Youcha, l985). The typical alcoholic home is marked by chaos, denial, emotional violation, and vulnerability, and children typically experience feelings of loss of control, worthlessness, and a dependency on secrecy for survival.

A few other common ACOA problems deserve note. (Zoldbrod, 1998). As with the children of battered women, the children of alcoholics become "parentified children" who have a great deal of difficulty letting themselves receive emotional nurturance. Socialization skills are typically weak, since ACOAs tried to maintain the family secret by not having peers visit them at home or having close friendships where too much would be revealed. Arousal and

orgasmic difficulties are caused by a negative association to losing control.

Research has proven a clear association between alcoholism, violence, aggression and impulsivity towards others in the family (NIAAA, Alcohol Alert #38-1997). Children of alcoholics typically deny or minimize the impact of their parent(s) alcoholism on their sexual development, ignoring the negative effects on their sense of trust, their expectation of empathy, self esteem, and socialization skills. If the family dynamic included violence, the sexual problems detailed above in this article will be relevant.

Child Abuse: A Broad Category of Neglect, Physical, Emotional, Medical and Sexual Abuse

Child abuse has been described as a national epidemic . In 1996, over 3 million children were reported to child protective services as victims of child abuse and neglect, translating to approximately 47 out of 1000 children, according to the National Child Abuse and Neglect Data System (NCANDS, 1998 report). In a breakdown of maltreatment cases, 52% involved neglect, 24% involved physical abuse; 12% involved sexual abuse; 6% involved emotional abuse; 3% involved medical neglect, and l4% involved "other types of maltreatment."

These are statistics based on cases actually reported to agencies. Much child abuse is not noticed by others. Different kinds of child abuse create different sexual sequellae. Children who grow up in homes where there is a lack of empathy and a dramatic abuse of power or violence, particularly if male, are prone to act out (Wolf, 1988) and according to research are more likely than other children to become sexual criminals (Pierce and Pierce, 1990.) Zoldbrod (1998) draws attention to the fact that male and female victims of intense physical abuse also "act in," experiencing sexual aversion, inhibited sexual desire, sexual dysfunction, and pain disorders.

According to Tzeng et al, (1991) psychological maltreatment is the most difficult type of child maltreatment to measure, and “probably causes the most serious impact on children’s psychological well-being.” Emotional child abuse and neglect create assumptions about human relationships which interfere with a wish for vulnerability and closeness as an adult. Examples of beliefs which must be changed in sex therapy are:

. If I get too close to someone I am not one hundred percent sure of, they will hurt and eventually reject me.

. Most people are not what they seem, and they usually have ulterior motives for things.

. It is better to do things on my own.

. Deep down, I am too needy and expect too much out of most people, and once they find out, they will reject me.

.Other people don’t want to hear my problems, really, and can’t change things for me anyway.

(Zoldbrod, 1988)

Mental Illness

Statistics collected by the National Mental Health Association in Alexandria, Virginia highlight the fact that many American families are made up of at least one parent with significant mental illness. According to the Surgeon General’s Report on Mental Health (1999) more than 54 Million Americans have a mental disorder in any given year, although fewer than 8 million seek treatment. Parents struggling with mental illness are hampered in their ability to parent with energy, consistency, and empathy. Depression and anxiety disorders are the most common, affecting 19 million American adults annually, according to NIMH (1999). More than 2.5 Americans have schizophrenia (according to Schizophrenia Bulletin, l998). Bipolar disorders affect an additional 2 Million Americans, according to NIMH (2000.) Severe child abuse and neglect is most common when parents have more serious psychiatric diagnoses. However children of

depressed caretakers can experience chronic emotional neglect. And children with extremely anxious caregivers absorb the anxiety passed through their caretakers’ body, leading to distorted associations to touch, difficulty with relaxation, and potential ambivalence about close attachments.

Conclusion

Sexual problems caused by non-sexual trauma are commonplace. Assessing the client's mastery of the Milestones of Sexual Development helps therapist and client to identify intrapsychic blocks to letting go sexually with a loved partner and to target treatment appropriately.

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Resource for Patients

Patients can download the diagram and explanation of the Milestones of Sexual Development on the internet at http://www.sexsmart.com .