
Damaged Development of the Human Affectional Systems and Developmentally Based Psychotherapy for Sexual Compulsivity

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Sroufe (2005) described the development of behavior as the result of developmental sequential events, each consequence influencing the next, falling like a set of dominos. Sexual compulsivity is the end of a series of developmental events that begin with genetics and temperament and emerge in early attachment difficulties with caretakers. Subsequently, overwhelming stressors render the child unable to assimilate beneficial life experiences and result in affect dysregulation, numbing, and avoidance. Impaired socialization and self-development contribute to intimacy dysfunction. The pubertal hormonal surge activates a biobehavioral reward system in which the individual retreats from others to survival mechanisms afforded by behavioral addiction. Easily accessible Internet pornography represents an escape from the demands of intimacy and a risk factor for the evolution of sexual compulsivity. This chapter will review the developmental psychopathology of sexually compulsive behavior with recommendations for psychotherapeutic intervention.

DEVELOPING HUMAN AFFECTIONAL SYSTEMS

The capacity for bonding with others is vital for human survival and well-being. Allan Schore (1994) emphasized the importance of the mother–child dyad in his review of the development of the brain and origin of self.

The child’s first relationship acts as a template and it molds the individual’s capacities to enter into all emotional relationships. Development essentially represents several sequential mutually driven infant–caregiver processes that occur in a continuing dialectic between the maturing organism and the changing environment. It now appears that affect is what is

actually transacted within the mother–infant dyad, and this highly efficient system of emotional communication is essentially nonverbal. (p. 7)

The mother’s attunement to her child facilitates the experience-dependent maturation of the child’s neurological structure, which directly influences the child’s biochemical growth process, as well as dendritic and axonal development, in the first year of infancy. “Hard-wiring” of the brain hierarchically, from lower limbic emotional structure, through the midbrain, and then cortical structures, occurs during this early, critical period (Maclean, 1962), so that genetic systems are either activated or inhibited by socio-emotional stimulation. Because 83% of the brain is differentiated postnatally, the human infant is maximally dependent upon its caretakers. If the child’s need for attention, soothing, stimulation, affection, touch, discipline, validation, and information goes unmet, or is met with feedback that is punishing, misattuned, frustrating, invalidating, or rejecting, the consequences can be structurally written into the developing personality.

Children may become emotionally constricted (Main & Solomon, 1995), turning into themselves and disconnecting from others, or emotionally dysregulated, failing to learn to utilize others to soothe or comfort themselves. These adaptations, in turn, increase children’s vulnerability to psychopathology. Children then actively seek familiar, consistent environmental interaction, thereby recreating and reenacting familiar early rejections and frustrations in new formats, with peers and in school (Sroufe, 1988). Some individuals, however, seem to be “saved” by novel experiences with a loving caretaker, teacher, friend, or therapist. These experiences prove transformative, influencing them to compensate with new cortical structures and learn relatively healthy attachments. Indeed, the purpose of psychotherapy is fundamentally to facilitate these transformations. As Schore (1994) emphasized, affect—not cognition—is the means of exchange in relationships, the client will not remember events; rather, emotions will be the primary form of communication.

More than four decades ago, Harry Harlow (cf. Harlow & Harlow, 1962, 1963, 1965) began a systematic investigation of the development and differentiation of affectional systems of rhesus monkeys. Implicitly, he understood that due to the increased size of primates' cerebral cortex, in comparison to that of lower mammals, the gonadal hormones would exert less control on mating behavior. This separation of mating from the menstrual cycle allows for mediation by higher-level systems, involving more complex factors such as attractiveness, solicitousness, courtship, and mating behaviors. Behaviors that may lead to mating were labeled “proceptive” by Frank Beach (1977), as distinguished from the acceptive copulation and conception phases (child care and delivery) of the affectional systems. This distinction has been useful across species for comparative psychology.

Many acceptive and conceptive difficulties are proceptive in nature. Sexual difficulties involving the genitals are frequently related to the capacity for intimacy. In the case of a monkey with experimentally induced developmental deprivation, the animal can copulate, but approaching a mate is associated with fear and ambivalence (Schwartz & Becklin, 1975; Schwartz & Senko, 1972). In the male monkey, this inhibition translates behaviorally into impulsive behavior, typically expressed by attacking mates violently. The female deprived similarly will bite her own body and cower. This model of differential effects of deprivation on male and female brains also holds true for humans (Sroufe, 1988). Sroufe found that avoidant boys were more likely to bully, lie, cheat, destroy things, brag, act cruelly, disrupt class, swear, tease, threaten, argue, and throw temper tantrums, whereas girls became depressed and blamed themselves. Early deprivation in both monkeys and humans (Putnam, 1997) is associated with definable biochemical changes in the brain and body that involve regulation of adrenal catecholamine, dopamine, and serotonin, glutamate as well as the opiate systems, which seems to mediate and exacerbate dysfunctional responsiveness (cf. van der Kolk, 1989).

The study of affectional systems, particularly proceptive disorders in humans, remain critical in understanding problems of intimacy and sexuality. John Bowlby's influence upon the field of developmental psychology included systematic study of actual biographical events that predictably damage the affectional systems (Bowlby, 1969, 1973, 1980). Several generalizations can be generated from Bowlby's model of attachment:

1. If the individual has confidence that the attachment figure will be available, he or she will be less prone to chronic fear;
2. Confidence in the availability, or lack of, the attachment figure is built up slowly during the early years and these expectations persist; and
3. Expectation of accessibility and responsiveness of the attachment figure is an accurate reflection of actual experience.

These propositions, which simply implied that biographical input is related to developmental output, were so radical that Bowlby was ostracized by mainstream psychiatry. Now, however, these principles form a bedrock of developmentally based psychotherapy of the affectional systems. Proceptive bonding disorders are probabilistically related to specific early insults to the differentiating early attachment systems (see Yeomans, Clarkin, & Kernberg, 2015).

Many cases of erectile dysfunction, sexual desire and arousal disorders are due to disturbances in the capacity for intimacy and closeness. The individual typically has had an experience in which a person with whom there bonding was both a source of comfort and fear. Being close is therefore associated with arousal and anxiety, leading to diverse protective dysfunctions. For example, Gillath and Schachaner (2006) indicated adolescent girls with avoidant attachment stated they felt numb when touched by a partner and were not sexually aroused.

When the template for intimacy is based on early experiences of terror related to neglect or abuse by the caretaker, opportunities for relationships can activate intense survival fears. The individual experiences the contradictory emotions of sexual arousal while simultaneously feeling fear and a lack of deserving kindness and affection. The fears can then either shut down potential sexual arousal or potentiate it.

A taxonomy of manifestations of intimacy disorders that are functions of childhood abuse, neglect, or the misattunement of caretakers is needed. In addition, paraphiliac (meaning “besides-loves,” in Latin) and other sexually compulsive disorders have proceptive, acceptive, and conceptive aspects to both their etiology and their course. For this reason, focusing on symptom change techniques in psychotherapy, such as relapse prevention, abstinence, arousal reconditioning, 12 step work, and social and empathy skills training, is necessary, but rarely sufficient. Successful treatment ultimately relies upon amelioration of the underlying attachment disorder and manifestations in adult intimacy.

VANDALIZED LOVE MAPS

John Money pioneered the study of structural and developmental contributions to the affectional systems., especially resulting in sexual manifestations. Like Bowlby, he believed that love maps can become “vandalized” by a variety of biographical events occurring between the infant and the caretaker in the early years of life.

During this critical period of brain differentiation, the child is programmed to establish gender identity, genital sexuality, and attachment to caregivers. Money (1986) defined a love map:

Personalized, developmental representation or template in the mind and in the brain that depicts the idealized lover and the idealized program of sexueroetic

activity with the lover as projected in imagery and ideation or actually engaged with that lover. (p. 10).

Events that block the differentiation and development of affectional systems can alter the love map. The developing love map would include proceptive events, such as the range of partner characteristics that arouses the body's response to touch or other contact with an attractive partner; the responsiveness of the genitals; and the sense of self as attractive and worthy.

Proception is influenced by a variety of emotions, such as illicitness, conquest, fear, intimidation, love, and challenge. The activation of a variety of proceptive templates from childhood is related to themes such as “saving a partner” or “getting back at someone who injured.” Sexual arousal templates are often re-enactments arising from affective interchanges with caregivers or attempts to remain attached with an abusive caretaker. Some theorists assert that development of the affectional system becomes delayed, fixated, or regressed, whereas others suggest that deviant development continues, but along a different, distinct, or complex route (cf. Calverely, 1990; Fischer & Bidell, 1997).

Resiliency, or the capacity to rebound, can be determined within the total context of developmental influences. If children believe that they are bad, defective, or damaged and attribute (or misattribute) the source of their “badness” to sexuality disorders may emerge. If a parent has unresolved rage related to his or her gender or shame related to sexuality (e.g., “I hate men,” “Sex is dirty”), the child can absorb the parent’s affect. The symptom becomes the recapitulation of the “vandalized love map” and often serves as a clue to developmental events of the child’s perceptions of biographical experiences, which deleteriously impacted the differentiating affectional systems. When the therapist is attuned to strong emotions of grief or rage that are manifested by the adult client in psychotherapy, these emotions become the window into the developmental disturbance.

A psychodynamic framework provides a tool for understanding developmental psychopathology in the evolution of sexual compulsivity (cf. Gomez, 1997; Horner, 1984; Marcel, 2005). Freud's (1896/1962) original model asserted that normal psychosexual development was thwarted by traumatic life experiences. Early erotic experiences overstimulated a vulnerable nervous system in the immature child. Ego defenses enable the child to grow, but lack capacity for genuine intimacy. The emerging individual may remember nothing of the original neglect or abuse. Instead, the injured person is driven to recreate actually or symbolically the "scene of the crime" to resolve the underlying trauma. The repetition compulsion or enactment of the pain and shame of the past represents the person's best effort to gain a sense of mastery and construct a more resourceful sense of self. Attempts at mastery often expose the individual to revictimization. Thus, the love map of a sex offender may be "fixated" and require "unblocking," or, alternatively, it may have differentiated along a distinct alternative pathway, suggesting that a new pattern of attachment needs to be "carved" or structurally developed in the brain.

EXPOSURE TO INTERNET PORNOGRAPHY

Exposure to Internet pornography in adolescence, especial among neglected or abused children, circumvents demands of real-life relationships and fears of attachment. Internet pornography becomes compulsive through anxiety reduction and involvement in highly stimulating sexual outlet at a safe distance. The compulsive pattern emerges as the adolescent disengages from interpersonal growth opportunities and relies increasingly on Internet use to manage emotional upheaval and negative mood states. Typically, for these individuals, more stimulation is required in terms of increased hours of use and search for novelty to overcome boredom or emptiness (i.e., tolerance effect). Explicit sexual images on the computer screen, usually paired with the powerful reinforcement of orgasm through masturbation, determines sexuality rather than through natural channeling of touch, closeness and affection. The fantasy or imagery a person uses to arouse oneself in

masturbation can then organize the choice of partner, affectional interchange, and sexual desire and arousal.

Repeated conditioning of the “love map” (Money, 1986) or erotic template (Cloitre et al., 2009) through involvement in Internet pornography or compulsive sexual behavior limits the capacity for intimacy with an intimate partner. Don Hilton (2017), discussed the neuroscience involved in problematic sexual behavior involving Internet pornography. Contrary to popular misunderstandings regarding the potential beneficial effects of Internet pornography, adolescent use can lead to distress and negative consequences.

...the ability to self-select material makes internet porn more arousing than pre-selected collections. Today’s porn user can also maintain or heighten sexual arousal by clicking to a novel scene, new video or fresh genre... Thus today’s digital porn, with its limitless novelty, potent delivery (hi-definition video or virtual), and the ease with which the user can escalate to more extreme material, appears to constitute a “supernormal stimulus.” (Hilton, 2017, para. 13). Such a stimulus has the potential for replacing the value of sexual experience with a real partner. Novelty and ease of access in pornography may contribute to rapid progression of sexual compulsivity in vulnerable users.

Excessive pornography use, including self-perceived pornography addiction, contributed to feelings of isolation and relationship difficulties (Duffy, Dawson, & das Nair, 2016). Park et al. (2016) reported increasing sexual dysfunction in young men associated with Internet pornography: decreased interest in partner-oriented sex and sexual satisfaction, delayed ejaculation, and erectile dysfunction. Limitless novelty and ease of progression toward extreme materials can condition sexual arousal away from interest in age-appropriate dating experiences toward isolating use of a device that produces physical dysfunction and psychological distress (Park et al., 2016)

A major issue in determining the risks of Internet pornography use is whether such behavior constitutes an addiction. Some clinicians and researchers involved in treating users of Internet pornography reported the behavior fits criteria associated with addiction, including tolerance and searching for novel and extreme stimulation; dependence upon extended periods of viewing to modify mood; and continued use without regard for negative consequences (Riemersma & Sytsma, 2013). Other researchers argued that it is the perception of Internet pornography use and exacerbation of guilt or shame associated with religious beliefs and values that produces the problem (Southern, 2017).

The proliferation of Internet pornography has influenced contemporary culture and adolescent development in many ways. Nearly 100 percent of adolescents across nations in the world use computers and hand-held devices to access the various media of the Internet. They check their devices and text or send images hundreds of times in a day. Frequent use typically begins in early adolescence with children as young as 12 years old accessing explicit images of genitals and sexual activities (Owens, Behun, Manning, & Reid, 2012). The Internet is a highly sexualized environment for most adolescents and some will come to rely upon medium for escape, release, and sexual conditioning. Involvement in excessive and ongoing use of Internet pornography has negative consequences.

Adolescent brains are especially susceptible to the bio-behavioral conditioning of sexuality through repeated exposure to Internet pornography (Owens et al., 2012). High levels of sensation seeking prime adolescents to pursue novelty and variant sexual material. Exposure to Internet pornography contributes to negative body image, low self-confidence, and unrealistic expectations regarding sexual performance and choice of sexual partner. As the pornography use becomes more secretive and isolative, there is impairment of social development. If these adolescents engage in sexual activity with a partner, it is not associated with emotional expression or pair-bonding experience. When Internet sexual

outlet becomes a preference or interferes with sexual functioning, the adolescent fails to gain psychosocial sexual competence. Young adults exposed to dehumanizing and violent sexual content are at risk for engaging in sexual coercion, aggression, or harm (Owens et al., 2012; Perrin et al., 2008).

Some educators and clinicians consider Internet pornography as a public health issue given the accumulating research on negative effects (Perrin, et al., 2008). Negative effects of adolescent exposure to Internet pornography include the following: (a) objectifying women or casting them in submissive or victim roles; (b) altering scripts for sexual interactions to avoid intimacy and embrace unrealistic and coercive elements; (c) reducing barriers for rape or justifying sexually violent attitudes; (d) engaging at younger ages in risky sexual practices; and (e) relying upon variant sexual images and activities as primary or exclusive means of outlet (Perrin, et al., 2008). While it would be possible for anyone to become trapped in the web of the Internet for sexual experience, children who have experienced trauma or struggle with attachment may be especially at risk for developing compulsive online sexual behavior.

ATTACHMENT AND SELF-SYSTEMS

Within the developmental model of affectional systems, critical capacities must be assimilated, or symptoms may emerge. These include affect regulation, social skills, perceived efficacy in attempting to negotiate social relationships, empathy and compassion for others, and capacity for accurate attunement regarding cues from others. These structural capacities set the stage upon which psychological drama unfolds (Greenspan, 1977), and these are the targets of developmentally based psychotherapies. Child abuse and neglect are common factors in the histories of individuals who manifest hypo- or hypersexuality. It is critical to dissect structural deficits that occur with abuse and neglect. It is necessary to return to the stage of stifled development and teach or encourage social and life skills needed to be secure and successful as an adult.

At the core of one's capacity to bond is self-empathy and the capacity for self-care. In the absence of alternative validating caretakers, the developmentally disturbed individual does not internalize a caring relationship with self. A child who is rejected or abandoned tends to develop negative core schemas or beliefs about the self. Accompanying modes of processing and organizing information (including affects) unfold in such a way that these beliefs become self-perpetuating. These modes ultimately organize an individual's range and type of interactions, constraining possibilities for new learning with respect to intimacy. The self comes to exist in the context of others, within an aggregation of experiences of the self in relationship. Invariant aspects of the self and others in relationship are abstracted into what Bowlby (1969) called "internal representational models." New experiences are then absorbed into earlier representations, creating and maintaining an individual who is distinct from others.

The individual also creates self-functions, which are tools to negotiate interactions with others, manage the intensity of the experience, and balance inner and outer experiences. Self-functions navigate the balance between old and new experiences by moderating intense feelings. *Availability of self-soothing and self-efficacy determines behavioral manifestations of balancing degrees of closeness and distance. When this balance is dysfunctional, rather than adaptive, intimacy disorders emerge.

One type of intimacy disorder originates when the child experiences a disorganized attachment (Main & Solomon, 1987; Sroufe, 1988). There seem to be two subtypes of adaptation. Anxious resistant attachment is characterized by anger with a caretaker when distressed. Anxious avoidant attachment involves chronic rebuff, cutting off emotion, and fear of caretaker. The infant becomes highly sensitized to soothing the caretaker, presumably to exert control and self-protection (Main & Solomon, 1987). The cost of surviving with each subtype is to give up the development and differentiation of an

autonomous self because sufficient safety is required to individuate. The individual attempts to create safety and consistency in maladaptive ways (i.e., distorted survival strategies). In the latter intimacy dysfunction, an adult repeatedly finds individuals who need care, which creates an illusion of safety and control. These adults become an extension of their partner's identity and their boundaries become blurred to the extent that it feels as though the other is vital to the self's survival. They simultaneously experience a need to merge, like a child with a caretaker, and a need to run for fear they will be engulfed or abandoned. They also experience ambivalence related to their need to rely on others for self-soothing, as opposed to being independent. If sexuality has also been injured in its unfolding, through association with violence or loss of control, ambivalence profoundly extends into the closeness/distance continuum. This ambivalence can be played out in a myriad of destructive ways, ranging from compulsive affairs to low sexual desire. In the first subtype, the motive of revenge and passive rage is most common, resulting in "perversion" according to the classic model of Robert Stoller (1975).

Deficits in the first year of life typically lead to self-cohesion difficulties, leaving the individual vulnerable to fragmentation. When an individual is dependent on a caretaker for survival and simultaneously fearful, the result is dissociation, one part of self feels dependent while another part of self is fearful. Involvement in compulsive sexual behavior allows distancing simultaneous to closeness, a survival strategy that is necessary but distressing.

Epstein (1997) observed that the result of internal self-fragmentation is the creation, metaphorically speaking, of "black holes that absorb fear and create the defensive posture of the isolated self — unable to make satisfying contact with oneself or others" (p. 5). Without basic integration, the individual experiences identity as many "selves" or feels like an imposter, due to an inherent experience of contradiction. Each of these "selves" has the capacity to produce behavior and has impulses for action. This fragmentation may explain

why some individuals find young children sexually arousing: a part of the self with a developmental age of 6–10 takes executive control but has the sexual arousal of an adult.

Where there is extreme internal encapsulation, a person can act with seeming integrity (such as a member of the clergy or the principal of a school), have multiple sexual partners, lie to others, and seem quite sincere, while not actually experiencing conflict or the implied contradiction. The mechanism of dissociation allows for the apparent anomaly in which “good people do bad things.” This explanation of deviant sexual arousal patterns is consistent with repeated findings of early neglect, abuse, and few or no early friendships in the biography of sexual offenders (Marshall & Barbaree, 1989; Schwartz & Masters, 1984).

During the 2nd and 3rd years of life, self-constancy is established. Children develop tolerance for separation and the capacity for self-soothing. They begin to internalize the belief that they are loved and valued, and do not need constant reassurance. Children form a positive self-object (Mahler, 1995), which allows them to experience an internal schema for being cared for in the absence of the caretaker. Children raised in state institutions in Romania who have been adopted in the United States may need to be told “I love you” by their caretaker a hundred times a day, because they do not have an internal structure to retain the belief (Chigani, 1997). Similarly, the person who engages in compulsive sexual behavior may need sex repeatedly to know they are supported by a caretaker or loved since they maintain such a high degree of self-hatred.

Individuals with intimacy disorders may lack a positive self-object and require others to provide continual mirroring to maintain their sense of self. They become highly suggestible and susceptible to influence. They chronically lack self-esteem and become human “doing,” rather than human “being,” because they experience themselves as being only as good as their last response. Men who have anonymous sex with multiple partners in a night may verbalize that they “feel only as good as their last trick.” This is like individuals driven to

make one business deal after another, at great cost to their family life, to attain more money, status, or other illusions of safety.

By 4 years of age, the child develops self-agency, the ability to operate in the world and actively create or elicit responses from others. The child develops a lexicon for affect and forms a framework for self-efficacy and mastery. The result of the healthy development of self-cohesion, self-constancy, and self-agency is self-esteem. Positive affect becomes integrated with self-representation.

The love map, which organizes self-functions and facilitates relational choices, is structured by the age of 5 or 6 years. Perceptions of what is attractive in oneself and one's potential partners are organized in the care of the love map. Persons with vandalized love maps maintain a confirmatory bias by selecting interactions with others in the environment. They choose relations that fit the existing core schemata and avoid or devalue relations that might refute central beliefs and affects. In this manner, the intimacy-disordered individual is held captive by the damaged love map until new learning can occur.

AFFECT REGULATION AND THE AFFECTIONAL SYSTEMS

Judith Herman (1992) observed that abused children develop maladaptive self-regulatory mechanisms. Abused children discover that they can produce release through temporary alterations in their affective state by voluntarily including autonomic crisis or extreme autonomic arousal. Purging, vomiting, compulsive sexual behavior, compulsive risk taking or exposure to drugs become vehicles with which abused children regulate their internal state. (p. 56).

The abused and neglected child experiences or anticipates abandonment, inequity, or conflict with caretakers, which leads to powerful feelings of rage, anxiety, and helplessness. Manifestations of such frustration are dangerous, given the child's dependence upon the

caretaker for survival. Protests may be actively suppressed by severe punishment, ostensibly “for the child’s own good,” (Miller, 1990) administered for “being bad.” Later stressors lead to reemergence of the powerful suppressed feelings of helplessness, rage, and anxiety, which then activate a search for tension-reducing behavior.

Tension reduction affords self-soothing anesthesia from pain and restoration of affective control, increasing the likelihood of repeating the behavior. Suppression of affect also is often accompanied by a “leakage” into somatic functions, such as eating, sexuality, or pain. The individual seems to express strong emotions by the “releases” inherent to compulsive behavior. These releases are exacerbated by increased autonomic arousal, which is chronically dysregulated by overwhelming trauma. Suppressed affect and cognition lead into consciousness during early adulthood (van der Kolk, 1989), and the individual experiences somatic memories and cognitions of early trauma experiences. In addition, symptoms of severe depression begin their onset (Putnam, 1997), as if the event is affectively remembered while the individual may cognitively remain amnesic. Such intrusions are often associated with increased compulsive behavior, which distracts and numbs the individual (i.e., a form of behavioral self-medication). It also expresses indirectly the intrusion’s referent (i.e., enactment instead of remembering).

If the discrete events were so traumatic that the child could not integrate or assimilate them, the result may be post-traumatic stress disorder. This disorder is characterized by abnormally highly sensitized and finely attuned hypopituitary axis with habituation and adaptations to chronic stress (decreased control and increased negative feedback regulation), that leaves the individual hypo or hyper responsive to a variety of stimuli” (Yehuda & McFarland, 1998, p. 168).

The result is alexithymia and an inability to use emotions as cues for action. Inability to recognize emotions, absence of internal emotional signals, and opiate receptor changes

occur in response to severe trauma (van der Kolk, 1989), causing analgesia to pain, anhedonia, internal dysphoria, confusion, and eventually sensation-seeking. These changes may lead to substance use disorders and behavioral addictions as attempted self-regulation. Addictive behavior can begin as a way to cope with a myriad of dysphoric emotions and a lack of internal self-cohesion. The addictive behavior can be maintained through habituation and generalization, although the source (cause) of the emotions is long forgotten. For the individual troubled with sexual compulsivity, acting out serves as a “release” and an expression of suppressed affect related to past injustice, which simultaneously reduces anxiety and causes the individual to become “high” from opiate release. These individuals then use the behavior as a form of self-soothing, develop a habit, and cognitively define themselves by their behavior (e.g., “I am a sex addict”).

When individuals are numb due to overstimulation or intrusion of dysregulated affect, they become able to “feel” by experiencing a “release.” When they feel overwhelmed by acting out, individuals can experience calming through the same mechanism of release that mediates a shift in internal state. Eventually, the individual may feel pleasure and safety only when acting out. The individual has bonded with the object of the addiction as a means of internal regulation and calming. The relationship with the object insulates this person from anticipated or real rejection from other people. For this reason, abstinence from acting out is often experienced by flooding of both affect and cognition. Recovery from addictive behavior may lead to the emergence of distressing thoughts and memories. Therefore, contemporary models emphasize concurrent treatment of addiction and underlying trauma (cf. Najavits, 2002). The goal of treatment is to reorient the addict from a state of constriction to begin relating to others for self-comfort. This begins a process of change to rebuild the structure of the self, attain control of affect dysregulation, and allow structural evolution of the affectional systems.

PSYCHOTHERAPY FOR DEVELOPING AFFECTIONAL SYSTEMS

With greater appreciation of early bonding disorders, there is some question as to how much change is possible after the ages of 8 to 10, much less in adulthood. Numerous studies have documented that amelioration of attachment disorders becomes more and more difficult as the child approaches puberty. The child with attachment problems has trouble showing concern for others, remains self-centered and impulsive, does not trust others, and exhibits many behaviors that are aimed at keeping people at an emotional distance (Sroufe, 1988, 2005; Sroufe, Egeland, Carlson & Collins, 2005). Other symptoms include poor eye contact, withdrawal into self, aggression, indiscriminate affection, over competing, lack of self-awareness, constant control issues, and delayed conscience development (Fahlberg, 1991).

Attention deficit disorder symptoms in school, sometimes manifested as defiant and delinquent behaviors, reflect early bonding disorders in many cases (Karr-Morse & Wiley, 1997). Acting out and aggressive behaviors in males, as well as depression and self-injurious behaviors in females, represent learned survival mechanisms. Clinical syndromes and addictive behaviors must be relinquished during the course of psychotherapy to promote intra- and interpersonal development. Ideally, there would be a period of abstinence from addictive behaviors with support for acquiring alternative coping skills.

Adults with histories of childhood neglect and abuse are notoriously poor reporters of such histories since many will consider their childhood “normal.” They blame themselves and identify with their psychiatric diagnosis. Rehabilitation initially is dependent on reexamining and contextualizing events of their lives. Because early events are encoded effectively, emergence of strong affect typically is a window into the disorder. The trauma reconstruction model focuses on “what happened,” rather than on “what’s wrong” with the person. Compulsive symptomatology always has biographical contributing factors and is

comprehensible within the “trance logic” or childhood associational processes from respective developmental ages.

Repairing vandalized love maps in psychotherapy requires revisiting critical experiences and reactivating the affect in the safety and containment of the therapist’s office, allowing for therapeutic reconstruction of core schema. This process includes “information reprocessing” through exposure therapy (Foa et al., 1991), which is demonstrably effective in the treatment of anxiety disorders. Refocusing strong affect on events in the dysfunctional family’s interactions allows for expression of affect and completion of the stress response cycle (Horwitz, 1997). Trauma reconstruction has been a central feature of effective psychotherapy since Freud’s pioneering work.

In trauma reconstruction therapy, the individual learns the self-functions that were never assimilated during childhood and adolescence. The developmental tasks are accomplished through role-playing and problem-solving in the “safe place” or “holding environment” (Winnicott, 1958) afforded by the therapeutic relationship. Specific skills are developed, as well as an overall sense of mastery or self-efficacy. Psychodrama and expressive therapy are extremely useful in practicing effective self-functioning. There is an active process of strengthening the self by learning how to interpret feedback and accomplish personally meaningful goals.

Developing the capacity for intimacy requires repair of the attachment system. A person’s internal working model requires a “template” that often does not exist when there is severe neglect. Brown and Elliot (2016) developed a technique to remap attachment representations using the “Ideal Parent.” The client is asked to imagine a different set of parents, ideally suited to their nature. This establishes a foundation for facilitating the growth through safety and exploration. The technique is often astounding to clients as they recognize the degree of emptiness they originally experienced. A love map with clearer expectations of self and

other is constructed, practiced, and then further developed through rehearsals within the therapeutic alliance, treatment community, friendships, and dating.

The most complex aspect of this rebuilding process is encouraging interactions with others who are not dysfunctional and preventing fears from sabotaging such connections. By allowing one's self to be genuinely supported by another (including the therapist), the self is "reseeded" and begins to have structures sufficient for continual growing. When fears are activated, insight and confrontation allow the individual to separate the past from the present, breaking the trauma bond. The goal of preserving loving interactions with their own children often is the initial impetus that motivates individuals to seek or maintain therapeutic experiences, even though they are terrified. In our experience, the human love map accommodates significant repair of even very severe early disruptions of attachment in individuals when they are "ready." The challenge to psychotherapy is recognizing when the client is developmentally sound enough to make changes and pace the therapy accordingly.

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