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## **Hyposexuality and Hypersexuality Secondary to Childhood Trauma and Dissociation**

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**ABSTRACT.** Childhood trauma can influence the bonding between the caretaker and the infant and thereby structure the stress response threshold. The capacity to utilize others as a form of self-soothing is determined by early attachments and also is critical to one's response to developmental stresses. The quality of early attachments strongly affects the capacity for adult intimacy. Early trauma and dissociative reactions have systematic effects on arousal, desire and pair-bonding, which are reviewed in this paper. A treatment model that addresses the early trauma and its aftereffects concerning intimacy and sexuality is discussed.

**KEY WORDS.** Sexual desire disorders, dissociation, attachment, trauma

### **CONCEPTUAL CONTEXT**

Sexual desire is such a complex multi-factorial developmental system that there is little published on the subject that provides a sound conceptual base. Hyposexuality implies that the sexual response is consistently inhibited, typically accompanied by low initiatory behavior; while hypersexuality is the result of a low threshold for sexual responsiveness, often with obsessive- compulsive rituals of

sexual expression that displace the unfolding of correction or caring for the partner. The rituals may also revolve around masturbation rather than partnered sex, or paraphilic sex, accompanied by a great deal of shame with a primary emphasis on relief of anxiety or tension. As with many addictive disorders, there can be a duality involving both over- control and out of control aspects that clinically seems to represent "two sides of the same coin," each with the common underlying organizing feature of fears of intimacy.

Often however, individuals are labeled or label themselves as hyposexual or hypersexual and the pattern becomes a dispositional trait or personality characteristic. Other characteristics may cluster around the central trait. Impulsiveness, rule breaking or sensation-seeking, may accompany hypersexuality, in contrasted with rigidity, over control, distancing from others, and withdrawal into self for the inhibited individual with hyposexuality. In relationships, one individual can be labeled as hyposexual, and the deprived other appears to compulsively desire sex, with escalating polarization occurring until the labels become entrenched and indeed appear to represent antithetical extremes. Additionally, as a further pathway, certain co-morbid psychiatric illness, such as depression, clearly lowers sexual appetite and medications quite often amplify such effects, leading to further symptom exacerbation and self-labeling, while dopamine agonists occasionally cause hypersexuality (Schwartz & Masters, 1975).

Sexual arousal and desire also define and are defined by the relational context. The experience of falling in love, for example, is often accompanied by hypersexuality, whereas relational boredom, fatigue, or hostility results in

hyposexuality. Sexual behavior later in life is also potently influenced by antecedent childhood experiences that are related to pair-bonding. Fears of abandonment, engulfment, dependency, or being controlled, and deep feelings of self-hatred all engender vulnerability in the capacity to form pair-bonds and subsequently, the capacity for sexual response.

Hyposexuality is most often used to describe individuals who do not have the desire for sex with a person they believe they love, such as a spouse or lover. Sexual desire is also quite responsive to situational performance failures, so for example, if the man repeatedly ejaculates rapidly, the woman may become hyposexual. In cases such as this, low sexual desire is easily reversed by performance successes or new partners.

Hypersexuality may frequently be dysfunctional. The hypersexual individual has been labeled by some writers as the "sex-addict" (Carnes, 1992), and the costs of such behavior can far outweigh the gratification. Yet such individuals seem compelled to continue, as with the high profile person who risks all in pursuit of sexual liaisons that are likely to ultimately be discovered. Typically, sexual acting out seems to produce an addictive "high," followed by shame. Some individuals' compulsive repertoires include illegal sexual activity with inappropriate partners, such as children or others who cannot give consent, or bizarre behavior such as inflicting pain or degradation on self or others. Compulsive sexual behavior can also include sex with objects, most notably recently the pornography or cybersex addict who may stay home masturbating, in preference to dating or spending time with a spouse. With compulsive hypersexuality, there seems to be a tolerance effect with an escalating level of intensity necessarily to get the same "hit," that seems to

substantiate the characterization of "addiction." The individual becomes preoccupied with sexual behavior in an obsessional manner and establishes a compulsive habit to cope with escalating distress. Cognitive distortions further embed the behavior in the context of an increasingly self-destructive lifestyle.

## **ATTACHMENT DISORDER AND HYPOSEXUALITY AND HYPER SEXUALITY**

Developmental psychopathology is a discipline that attempts to explore the developmental multi-determinants of adult psychiatric disorders by identifying those experiences that leave individuals vulnerable with respect to subsequent stressful life circumstances. The premise is that individuals establish varying vulnerabilities or resiliencies based on their first bonding experience. These early experiences then dictate the range of what individuals are reactive to, and to what degree they react. Some crucial determinants of the earliest bonding experience include the presence or absence of appropriate and timely response to the child's critical needs for attuned stimulation, soothing, attention, safety, affection, consistency, limit- setting, and touch. Bowlby's (1980) formulation was that attachment systems in infancy prepare the child to regulate arousal by effective utilization of others for self-soothing and self-control. In Alan Shore's (1999) words, development "essentially represents a number of sequentially mutually driven infant-caregiver processes which occur in a continuing dialectic between the maturing organism and the changing environment" (pg. 64 ). This first relationship then acts as a "template" by which the individual enters into all subsequent emotional relationships. The result is varying levels of vulnerability and sensitivity to stressful events in which coping or "survival"

strategies established during childhood become the root of either healthy functioning or adult psychopathology. For example, a child whose depressed mother is unresponsive to the child's smiles will disengage, become autonomically activated, and ultimately retreat into his own body for self-soothing (Tronick, 1989). This pattern becomes the basis of an adult intimacy disorder wherein the individual avoids using the pair-bond for comfort. This avoidance likewise translates into the sexual response realm. Unable to find soothing through intimacy, the individual remains unsatiated by orgasm.

Institutionalized children move through cycles of protest, despair and apathy, (Bowlby, 1980). Apathy may become characterological and is classically symptomatic of a long-term attachment disorder. Abused children will hypervigilantly watch their mothers (Main, 1993), as if to take control by soothing their caregivers, but at the cost of relinquishing exploration of their environment and thereby establishing the capacity for mastery. These children are then more susceptible to cruelties from peers and neglect from teachers (Stroufe, 1983), which then further compounds their vulnerability to stresses. Chronically abused children may display classic signs of Complex Post-Traumatic Stress Disorder (Herman, 1992; van der Kolk, 1996), which includes depression, anxiety, somatization, dissociation, addiction and relational/sexual difficulties with susceptibility to revictimization at different trajectory points in their development. In adult relationships, safety in close relationships is often maintained by anxiety-driven over-control, which typically causes relational power struggles.

One central component of Complex **PTSD** has been characterized by the term "disorders of the self" (Masterson, 1988), defined in part by the presence or absence

of various self- functions. A self-function is a boundary defining capacity which arises from the individual's sense of self-perception, self-esteem, self-agency and self-efficacy, all of which effect the individual's appraisal of others' feedback and ultimately their overall interactions with others (Shane, Shane, & Gales, 1997).

Affect awareness, expression and control also constitute self- functions. Given that sexual desire is an aspect of pair-bonding, factors contributing to or inhibiting the capacity for pair-bonding also define the parameters of sexual arousal. In a sense, sexual desire can be considered a self-function that is critical to how individuals define themselves in relation to others and how they bond with others.

When significant deficits and impairment of self function exist in a person, Greenspan (1989) suggests that such an individual "lacks critical capacities, called structural capacities which are central to self-regulation, (security, control, dependence), relating (affection, bonding, trust), pre-symbolic affective communicating (self in relation to others), representing and differentiating experiences and self observation (wishes and intentions) and boundary-defining gestures (mastery, social skills)" (pg. 57-59) Each of these structural capacities is central to sexual functioning. Initiating a pair-bond requires a realistic self-appraisal. If individuals consider themselves bad, defective, undeserving, damaged or unable to care for themselves, their ease in approaching potential mates would clearly be hampered. Boundary defining gestures, such as looking the other in the eye, social and dating skills are necessities in defining the nature of a dating interaction. After a contact is made, the individuals need to negotiate the boundaries of the relationship. An individual's need to care-take the other and ignore self-needs, to do things "perfectly" and seek the other's approval, are examples of manifestations of

constraint or impairment in the arena of structural capacities. This type of formulation has led clinicians to conceptualize the entity of the sexual disorder more as a product of a courtship capacities deficit and consider the sexual problem as secondary to the prospective love disorder (Money, 1985).

For individuals with impairment of self-function, self-perceived ineptness in dating or mating interactions evokes feelings of incompetence, stupidity, dependence, self-hate, defectiveness and shame. These feelings persist even if they sense that the other likes them and that the feelings are irrational. It is as if the deeply engrained affective patterns related to their first attachments activate feelings of defectiveness even when the current situation suggests the opposite. Such individuals are prone to self-sabotaging behavior as if to unconsciously recreate the early reflections of self received in primary relationships. Sexual desire in such cases can be largely anxiety driven, as the desire to conquer the other, or multiple others. In order to continually feel accepted, the individual is driven to compulsively seek affirmation of their acceptability as a way of combating deep self-hatred. Thus, hypersexual individuals starving for attention, affection, touch or validation, but without the structural capacities to substantially meet these needs, can achieve a tenuous, fleeting sense of reassurance and pseudo-intimacy.

Hyposexuality, on the other hand, sets up a shield to protect the individual from anticipated rejection and prevent the vulnerability of allowing another close enough to recognize perceived self-defectiveness. When the template formed was based on an early experience of terror related to abandonment or engulfment by the caretaker, potential 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. It is therefore, quite common for one individual to be both hypersexual and hyposexual within the same or different periods of their lives. Their extremes of responsiveness seem contradictory, but are actually a predictable adaptation to a set of complex overwhelming contradictory internal cognitive-affective, behavioral structures, evolved in response to original rejection, abandonment, neglect, assault, and resultant re-creations and misappraisals.

Treatment of such contradictory internal representations may require exposure to the original fearful childhood events (Foa, 1986) that shaped such core self schema, with information reprocessing (Resick, 1996) to permit realistic cognitions to replace the original fear-based ones (Fonagy, 1997). The model has been described as reliving-revising-revisiting (Glaser, personal correspondence; Schwartz & Gay, 1996) in that clients reexperience the fears and other overwhelming affect in the safety and containment of the therapist's office. They are then coached to question their original conclusions about self, sometimes utilizing hypnosis, internal family systems therapy (Schwartz, 1995) eye-movement desensitization and reprocessing (EMDR; Shapiro, 1995), psycho-dramatic or gestalt therapies. In the revisiting stage they are taught self-functions and repair of structural capacities that are deficient from developmental deprivation and misappraisals.

Also highly critical to sexual arousal is the capacity for affect regulation that is initially established by the external responsiveness and guidance of caregivers. When the caregiver is attuned to the excitatory and inhibitory cycles of the child, an internalized sense of control is established. In neglectful or abusive families, affect

regulation is often inconsistent, over- controlled or non-existent. A lack of such internal control can underlie the over control and/or out of control of sexual impulsiveness.

As a child matures, parents lend their capacities to apprise self-functions to the child, providing mirroring. This capacity is described by Fonagy (1997) as "reflective function." Relative to sexual unfolding, if, for example, a child's touching of her own genitals is witnessed by a parent and responded to with a punitive affective response, the child comes to encode sexual urges as bad. If, as another variation, a child's father is caught in an affair by the mother and the child views the mother having a violent response, the sexuality of men generically can become negatively coded. Even though the context of these events can be lost to memory, the affect can be stored in the unconscious representational systems related to future pair-bonding of the child.

Prolonged negative affects, affective dyscontrol by caregivers, and habitual caregiver hostility often lead to fear of the caregiver. The need for safety and bonding is then contradicted by fear, both very strong primary emotions. The result is often psychopathology and resultant intimacy disorder. Children for whom this is the case display failed attachment and lack the capacity to understand the minds and feelings of others (Fonagy, 1997). In extreme cases, such a severe mixture of primary emotions can result in paraphilia (Money & Schwartz, 1983); the individual is not aroused by other adults but alternative stimuli, e.g., children, shoes, or particular objects. It is as if sexuality emerges within a context of shame, fear and self-hatred and thereby becomes "hardwired" to deviant substitute objects during puberty. At the other extreme, reflective function that associates negative emotions

with emerging sexuality results in too much inhibition, stigmatization or isolation from social interaction, and suppression of affect. In such cases, anxiety can become amplified and result in avoidance and/or inhibition of natural bodily functions.

When, however, individuals feel a build up of tension from unresolved feelings of rage, anxiety, helplessness, self-loathing and/or emptiness, they will then turn to sexual behavior as a temporary distraction to provide interruption of the dysphoric state, resulting in restoration of control and a temporary feeling of relief from the emptiness, or self-soothing. A sense of calm and relief ensues, perpetuating the over-control/ out of control cycle.

## SEXUAL TRAUMA AND DISSOCIATION AND SEXUAL AROUSAL

Sexual abuse is a particularly pernicious form of trauma in that it disrupts the development of the self-system, affect regulation, and a sense of safety in interpersonal relationships at critical stages in development. When sexual abuse occurs, sexual arousal often becomes activated prematurely, but within a context of betrayal, fear, confusion, shame, and violence. The oft accompanying destruction of the sense of safety within the child's home, body and of trust in the caretaker's ability to provide protection, and trust in significant adult figures generally, creates enduring feelings of personal vulnerability. Self-perception is damaged, and a sense of badness or core defectiveness results (Summit, 1983) alongside a sense of powerlessness and loss of control over body as well as environment. These losses and the associated fears and anxieties that accompany them interfere with the developing capacity for intimacy.

The long-term effects of early abuse on adult sexuality vary. They depend on the child's age, duration of the abuse, relationship with the perpetrator, sex of victim and victimizer, previous trauma, and the way the event is processed, as well as the counteracting effects of positive, reinforcing early attachments and the stability of the family environment,. The most common response is hyposexuality in close intimate relationships and hypersexuality with new partners.

The latter is often a reenactment of the original incident repeated over and over. Stoller (1968) has characterized this element of compulsive reenactment as "perversion," and describes how it provides a sense, though perhaps misplaced, of "triumph over tragedy," in the sense that, seemingly, this time the victim chooses, rather than submits. The driven-ness of the need to repetitively reenact a once traumatic event can hardly be said to signify resolution. Instead, it is as if the brain is unable to assimilate the overwhelming, confusing and often contradictory behavior, affect, sensations, and knowledge implicit in the sexual abuse and thereby drives the person to repeat in order to finally establish a solution. While frenzied reenactment constitutes phase one, once the individual becomes intimate, trauma-engendered core fears of closeness and hatred of self become activated, neutralizing sexual desire. Thus, hypersexuality gives way to hyposexuality.

Braun's (1985) BASK model of dissociation, that is, the segmentation of behavior, affect, sensation, and knowledge is extremely applicable to sexual arousal. Dissociation of affect might include experiencing feelings of terror, numbness or confusion without any apparent cause, or experiencing affect incongruent with the present situation. It has been noted that many men in this culture highly dissociate

from affect. Unaware of a myriad of emotions and feeling distant and disconnected from their partners, sex is experienced as a need for ejaculation rather than intimacy. Some individuals can have sex without affection because of dissociated affect. On the other hand, a person might experience sexual apathy or impotence because the individual is terrified but unaware of it. Unable to use fear or terror as a signal, some individuals attempt to "perform," but genital vasocongestion is blocked by fear.

Dissociation secondary to childhood trauma also becomes a mediator of sexual desire. Behavioral dissociation is, for example, common with men who perform anonymous sex with strangers whom they often do not like nor find attractive, men who put their penises through holes, without knowing who is on the other side, for the purpose of oral genital contact, or women who function repeatedly as prostitutes. In some instances, such dissociated behavior serves as a reenactment of the original trauma. A part of the self will revisit the experience of childhood rape repetitively, to repeat the danger and excitement, in an attempt to complete the stress response cycle.

Dissociation of sensation may manifest in numbness, headaches or sickness or pelvic pain with no medical explanation. Touching one's partner sexually may be experienced as comparable to touching an inanimate object by one person, while to another, it may signal a need to immediately orgasm. The sensory systems of sexually traumatized individuals are particularly prone to injury. When sexual unfolding occurs prematurely and within a context of force, coercion, brutality and objectification, elements become intertwined that under healthy, developmentally appropriate circumstances would not be linked. This phenomenon, in its myriad manifestations, is known as trauma bonding (Schwartz, Galperin, & Masters,

1993). The most damaging fusion of elements perhaps, is the pairing of terror with sexual arousal. One client with dissociative identity disorder described how she experiences this phenomenon relative to the responses of her internal self system:

*I don't know that we've ever experienced true sexual arousal - only fear arousal, arousal driven by terror, anxiety or excitement that is basically over-stimulation. When we feel these, it translates into a physical response in the vaginal area. p. 36*

For this client, natural unfolding of sexual response at a normal developmental level was brutally preempted by the repeated, unpredictable evoking of sexual responsiveness by others who exercised virtual life and death control over her. When the arousal potential of the child is prematurely forced to unfold at the behest of an all powerful adult using that child's body as a receptacle for hostilely driven release, arousal is equated with danger. The weight of an adult body crushing a child, a silencing hand over nose and mouth, and a whispered threat not to tell, or else... is hardly the stuff of romance, or is it? So much of what passes for "erotica" recapitulates themes of subjugation, infliction of pain and disconnection. One wonders whether the target market is not chosen with a clear sense of capitalistic pandering to the driven-ness that accompanies sexual pursuits by individuals who recapitulate the insults or injuries to their unfolding affectional and/or sexual system during their early development. Whenever child sexual abuse occurs at the hands of trusted others upon whom the child has previously relied for safety, the degree of dissociation and self fragmentation required to contend with it is exponentially increased, especially

where the child must continue to rely upon these others.

Compounding the original damage, later in life, the individuals may view their trauma bonded sexual responses as "evidence" that original perpetrators were correct in their ascribing of "innate badness" to them, as part of the ostensible rationale for the original abuse.

Van der Kolk and van der Hart (1989) have suggested that dissociation can be primary, secondary, or tertiary. Primary dissociation results in persons feeling objectified and depersonalized and, in turn, considering others as objects to use for their narcissistic satisfaction. They "fuck" or are "fucked," to use the colloquial term, but typically feel the pleasure of physical release with minimal bonding or connectedness with the partner, and also with less satiety. Primary dissociation is exemplified by some ambisexual individuals (Masters and Johnson, 1972) who will have sex with men or women without any specific preference, attraction or bonding. The individual appears numb and disconnected from self and others, using orgasm as an escape from emptiness. In some such individuals' histories, they survived overwhelming experiences by dissociation, and now appear to dissociate involuntarily. Many individuals seem to have less extreme, unconscious fears of the vulnerability of being close and nude with lovers, and dissociate. In order to then feel, they require illicitness, pain, novelty or romance to experience arousal.

Secondary dissociation, according to Van der Kolk et al. 1989, results in a person having the sense of leaving their body and not actually being present for sexual interchange because of the terror of being close or due to flashbacks to prior abuse. The individual either experiences hyposexuality and is numb, or

"bypasses" the emotions and is able to perform with many partners in a mechanical way, with seemingly little desire or arousal. Typically, this was the defense utilized when no escape was possible from prior physical onslaught and now, even chosen opportunities with select partners still contain triggers- certain touch, words, tastes, smells, (1989) sensations-that automatically cue the protective response of dissociation.

Finally, Van der Kolk et al's definition of tertiary dissociation implies fragmentation of the self into disparate ego states (Watkins and Watkins, 1971) that function at cross purposes. When there is a history of sexual abuse, often there is a part of self described as a "seducer or seductress," which will "conquer" desired partners utilizing sex. However, after the partner is committed, the body is often hyposexual. Ironically, but not unpredictably, once genuine intimacy and trust enter the picture, it may be more difficult to override fear through reliance on more robotic parts of self. Other aspects of tertiary dissociation result when encapsulated child parts that are frozen in time "come out" during sex with cognitions and affect that are trauma coded, e.g., "sex is yucky or dirty." Obviously, in such cases, some measure of trauma resolution and integration of split off parts of self is essential before attempting sexual therapies.

When there is secure attachment and minimal childhood trauma, an individual develops pride in their self-identity, their gender, and their sexuality. They are able to move into an intimate relationship, use others for self-soothing, and internalize self-soothing and other capacities, thereby evolving both autonomy and interpersonal relatedness. They continue to know more of their identity through close relationships and do not fear losing themselves in their

dependencies, nor their partners in their solitude. In such cases, sexuality becomes a natural manifestation of affection, with fluidity in appetite, resembling that for food.

Conversely, damage to the self-system results in activation of fears of intimacy when the individual is in a position to be sexually vulnerable. Individuals described as having avoidant attachment by Ainsworth and her colleagues (1978) seem to develop a long-term characterological avoidance of closeness. Bowlby (1980) notes that "when such an individual attempts to live his life without the love and support of others, he tries to become emotionally self-sufficient and may be diagnosed as narcissistic or having a false self," as described by Winnicott (1978). Such narcissism was exemplified by a recent client who had multiple affairs with patients in his medical office while his wife was pregnant. He stated, "I am not sure I love my wife or that I have ever loved or am capable of loving." Instead, he was hypersexual and seduced women compulsively, as if sustaining a cohesive sense of self was dependent on their presumed receptivity. When his mother came in for a family assessment, she displayed active avoidance of her grandchild. When we inquired about this behavior, she acknowledged that after her husband left her with the young children as the result of an affair with another woman, she never again "allowed herself to love anyone or anything." When this same client entered marital therapy with his wife, we noted that he was consistently hyposexual.

We propose that the treatment of a specific triad of symptoms - disorders of self, affect regulation, and interpersonal relationships - requires highly individualized trauma-based and integrative therapies. Such treatment should

focus on the resolution and integration of developmentally overwhelming events in a time-limited format. A strong relationship with the therapist is requisite for such work. Directive techniques for neutralizing therapy, life and relationship interfering behavior (Linehan, 1993) can be utilized to counter common resistances. This phase of treatment is followed by placing the individual into therapy with the partner or spouse and using the relationship as a further vehicle for change (Schwartz & Masters, 1988).

The couple is asked to live in a hotel for 10 days away from daily pressures and given specific suggestions by a co-therapy team to catalyze increasing levels of intimacy in and out of the bedroom. The roadblocks, structural deficits or fears that have interfered with sexual desire usually manifest themselves, and directive psychotherapy is used to intervene and teach new skills. Cognitive behavioral therapies are utilized to enhance the couple's skills at intimate interchange such as: problem-solving, demonstrativeness, responsiveness to other's needs, creativity in socializing, methods of dealing with long-term hostility and ambivalences with closeness, vulnerability, trust and bonding. Each therapy session is both diagnostic and therapeutic, because more information about the individual's structural deficits and how they become manifest in the relationship is gleaned from processing the events and interchanges of the prior day. The therapist actively (1) confronts the destructive transaction, (2) points out it's origin and, (3) puts in current perspective it's potentially destructive consequences, (4) offers skills to improve or change the behavior, and (5) provides suggestions of ways of practicing the new skills between the sessions. When the client becomes stuck or unable to benefit from cognitive-behavioral

suggestions, the stuck point is used as a window into deeper unconscious conflicts, not completely resolved from the individual therapy. At this juncture, trauma-based exposure and information reprocessing therapies are used with the spouse in the room and the couple is sent home with suggestions of how to further share emotions and responses emerging from the deeper work. In this way, intimacy is facilitated in the therapist's office - in vivo – and its building is continued between sessions. Suggestions for sexual intimacy through sensate focus exercises (Masters & Johnson, 1972) are integrated into the newly created safety and closeness of the intimate relationship, reversing many of the sensory integration issues that began in early attachment deficits or childhood trauma. Such exercises also emphasize shifting attention to the partner using mindfulness, which typically begins to neutralize the automatic dissociative patterns, and allows for novel and ameliorative experience in the here and now.

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## REFERENCES

- Ainsworth, M. Biehas, M., Wateres, E., & Wall, S. (1978). *Patterns of Attachment*. Hillsdale, NY: Erlbaum.
- Bowlby, J. (1980). *Attachment and Loss*. Vol.3, Loss, New York, NY: Basic Books.
- Bowlby, J. (1978). *Attachment and Loss*. Vol. 2, *Separation*, New York, NY: Basic Books.
- Braun, B.G. (1985). "The transgenerational incidence of dissociation and multiple personality disorder, a preliminary report." In Braun B., *Childhood Incidence of Multiple Personality*, (pp. 225-290). Washington, DC: American Psychiatric Press, New York, NY.
- Carnes, P. (1992). *Out of the Shadows*. New York, NY; Bantam Books
- Cicchetti, D., & Cohen, D. (Eds). (1995). *Developmental Psychopathology: Theory and Method*. New York, NY: Wiley.
- Foa, E. B., & Koyak, M. (1986). "Emotional Processes of Fear: Exposure to Corrective Information." *Psychological Bulletin*, 99, 20-35.
- Fonagy, P. & Target, (M) (1997). *Attachment and Reflective Function, Development & Psychopathology* (pp. 9, 679-700)
- Greenspan, S. (1989). *Developmental Psychotherapy*. New York: International University Press. Herman, J.L. *Trauma and Recovery*. New York, NY: Basic Books.
- Herman, J.L., Perry, J.C, & van der Kolk, B.A (1989). "Childhood Trauma in Borderline Personality Disorder." *American Journal of Psychiatry*, 146, 490-495.

Linehan, M. (1993). *Cognitive Behavioral Therapy for Borderline Personality Disorders*. New York, NY: Guilford Press.

Masters, W., & Johnson, V. (1972). *Human Sexual Inadequacy*. Boston, MA: Little Brown.

Masterson, J., & Klein, R. (Eds.) (1988). *Psychotherapy of the Disorders of Self*. New York, NY: Brunner/Maze.

Money, J. (1986). *Lovemaps*. New York, NY: Irving Books.

Resick, P., & Schnicke, M. (1996). *Cognitive Processing Therapy for Rape Victims*. Newbury Park, CA: Sage Publications,

Schwartz, M., & Gay, P. (1996) *Physical and Sexual Abuse, Neglect and Early Disorder Symptoms*. In M.F. Schwartz & L. Cohn (Eds.) *Sexual Abuse and Eating Disorders*, (pp. 15-30). New York, NY: Brunner/Maze.

Schwartz, M. & Masters, W. (1988). *Inhibited Sexual Desire: The Masters & Johnson Institute Treatment Model*. In S. Leiblmn, & R. Rosen, (Eds.), *Sexual Desire Disorder*, (pp. 18-45). New York, NY: Guilford Press.

Schwartz, M., Galperin, L., & Masters, W. (1993). "Sexual Trauma within the Context of Traumatic and Inescapable Stress and Poisonous Pedagogy." In M. Hunter (Ed.), *The Sexually Abused Male, vol. 3*, (pp. 1-21). New York, NY: Lexington Books.

Schwartz, M. F. (1983). "Effects of Fetal Androgen and Behavioral Development of Young Adult Females." *Psycho-Neuroendocrinology*. June 15, (pp. 350-362).

Schwartz, C., R., (1995). *Internal Family Systems Therapy*. Guilford Press.

Shane, M. Shane, E., & Gales, M. (1997). *Intimate Attachments Toward New Self Psychology*. New York, NY: Guilford Press.

Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing*. New York, NY: Guilford Press.

Shore, A. (1999). *Affect Regulation and the Origins of Self*. Hillsdale, NY: Erlbaum.

Stoller, R. (1975). *Perversion: The Erotic Form of Hatred*. New Haven, CT: Yale University Press.

Stroufe, L.A. (1983). "Infant-caregiver Attachment and Problems of Adaptation in the Preschool." In M. Perlmutter, (Ed.), *Mind Symposium and Child Psychology*, Vol. 16 (pp. 236-259). Hillsdale, NY: Erlbaum.

Summit, R. (1983). "The Child Sexual Abuse Accommodation Syndrome." *Child Abuse and Neglect*, 7, 177-193.

Tronick, E. (1989). "Emotions and Emotional Communication in Infants." *American Psychologist*, 44, 112-119.

Van der Kolk, B., McFarland, A.C., & Weisaeth, L. (Eds.) (1996). *Traumatic Stress: The Effects of Overwhelming Experience on the Mind, Body & Society*. New York, NY: Guilford Press.

Van der Kolk, B.A., & van der Hart, O. (1989). "Pierre Janet and the Breakdown of Adaptation in Psychological Trauma." *American Journal of Psychiatry*, 146, 1530-1540.

Watkins, J. (1971). The affect bridge. *International Journal of Clinical Hypnosis*, 19, 21-27.

Winnicott, D.W. (1958). Psychosis & children. In D.W. Winnicott, *Collected papers from Pediatrics in Psychoanalysis*. London: Tavistock.