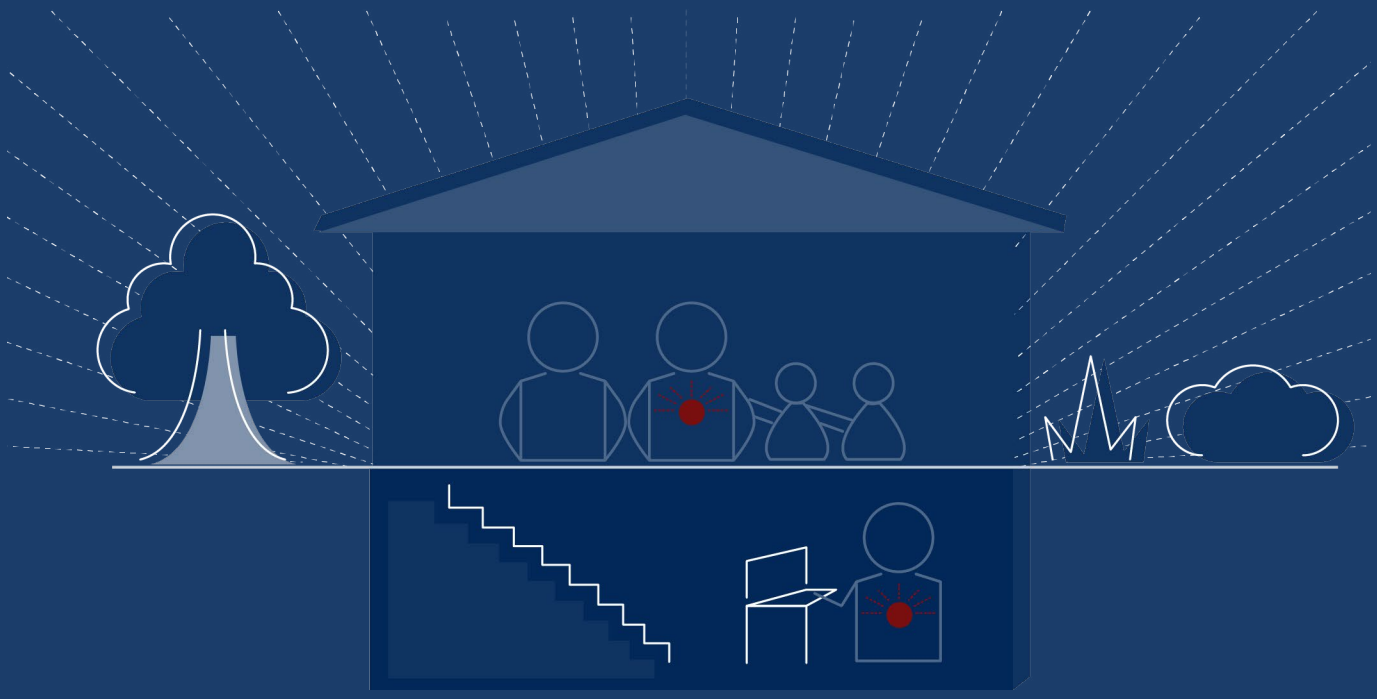

# Deceptive Sexuality and Trauma (DST):
## A Clinical Model

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# Note from Dr. Minwalla

This paper introduces the term **deceptive sexuality** to refer to a type of intimate partner violence and domestic abuse. Deceptive sexuality involves someone having a deceptive, compartmentalized, sexual-relational reality in the context of an intimate relationship(s) or family system. Think of it as something like a Secret Sexual Basement – a place that houses a person's deceptively hidden sexual, romantic, and/or emotional intimacy with others that is not shared with the primary intimate partner. A place that is characterized by an **ongoing system of psychological and relational control, domination, violation, and harm.**

Now, what if I told you that we all collude with this type of abuse? As a society, the abuse and trauma caused by deceptive sexuality are buried in the shadows of our collective normalization, denial, lack of insight or awareness, and silence. We reduce a whole long story of abuse, trauma, harm, and injury to a narrow focus on sexual behaviors (or infidelity). We don't recognize the complicated and overwhelming system of abuse that may have, for many years, been inflicting devastating wounds and long-term injuries. We render this abuse largely unrecognized and unconscious, pervasive and yet protected. Through our collective denial, avoidance, confusion, passivity, and – most importantly – complicit silence, this type of abuse continues, unchallenged.

For the last 15 years, I have worked as a treating psychologist, on the front line, as a first responder, with people dealing with deceptive sexuality. It has literally taken me this long to recognize and clearly articulate that a type of domestic abuse is at the heart of deceptive sexuality. That this abuse causes significant trauma among its victims. And that we, as a treating profession, need to properly diagnose and treat this abuse problem.

Accordingly, the core of my work attempts to:

- **remedy the victim-blaming and diagnostic mislabeling of deceptive sexuality victims**
- **designate a name for the abuse disorder associated with deceptive sexuality**
- **develop effective treatments for victims, abusers, and the injured relationship(s) of deceptive sexuality**

This is a call for illumination. Not just clinical illumination for professionals treating deceptive sexuality, but for all of us as people. It is my hope that we all can help shine a spotlight on deceptive sexuality, not simply as a "moral issue" and not simply as a "sexual agreement or infidelity violation," but as a form of violence – an abuse disorder that causes significant clinical injuries and symptoms. And that once we see this serious problem more clearly, we can envision the promise of actions and solutions.

This paper is an introduction, an attempt to provide an overview of a grounded theory and clinical model for deceptive sexuality called the Deceptive Sexuality and Trauma (DST) Model.

My part in helping shine a light.

Sincerely,
Dr. Omar Minwalla

# What is a Deceptive, Compartmentalized, Sexual-relational Reality (DCSR)?

Couples and individuals dealing with problematic sexual behaviors might typically hear the terms compulsive sexual behavior disorder or sexual addiction used to describe their experiences. But these words don't fully capture all of what actually goes on in these situations. An exclusive focus on sexual behaviors is incomplete, as problematic sexual behaviors are often accompanied by a tragic pattern of abuse and injury that deeply impacts partners and family members for years.

Most people who struggle with repetitive and problematic sexual behaviors and seek clinical intervention are in relationships (often intimate partnerships or marriages) and may be parents as well. In fact, most clinicians working with these individuals indicate that one of the primary motivators for treatment is the impact on the partnership, the marriage, and/or the family.

What has not been typically focused on in any of the dominant diagnostic and treatment models is that patterns of repetitive and problematic sexual behaviors are often part of a deceptive, compartmentalized, sexual-relational reality (DCSR) within the context of the intimate relationship. DCSRs are intentionally hidden and separated from the rest of the person's life and reality (sort of like a secret sexual basement), which has a huge negative impact on the person's partner and family.

To create and maintain a DCSR (or deceptive sexuality) within an intimate relational context, a person has to violate the boundary of fidelity and corrode the conditions of healthy relational functioning – respect, trust, honesty, and integrity – to such a degree that the partner often experiences psychological, emotional, and relational abuse. This type of deceptive compartmentalization effectively keeps things hidden from people who are dependent on the person's sexual-emotional-relational integrity and fidelity. If discovered and/or confronted, abusers will often defend themselves and blame the victim or the relationship, rather than assume responsibility for the deceptive, compartmentalized, patterns of sexual-relational behaviors. These defensive behaviors and callous attitudes often cause additional psychological, emotional, and relational abuse and harm.

Both abusers and their partners may seek professional treatment and be in need of clinical support. Unfortunately, we lack a formal, professional consensus on how to best diagnose and treat the issue of deceptive sexuality.

A DCSR can involve:

- intentional psychological manipulation of the victim's reality, causing second brain injury
- chronic utilization of deceptive tactics and covert management
- an ongoing psychology and system of violation, control, and covert domination
- chronic patterns of lying / lying by omission
- corrosive negative justifications to externalize blame onto the victim or the relationship
- erosion of relational integrity

# What's Wrong with Traditional Clinical Models of Sexual Acting-out Behaviors?

Traditional clinical models for understanding sexual acting-out problems have tended to focus solely on the sexual behaviors themselves, while missing or ignoring the chronic sociopathic[1] and abusive behavioral patterns that are often associated with deceptive sexuality. Essentially, these models have concentrated on only one part of a two-part problem. In doing so, they have neglected and omitted other significant problematic behaviors from clinical recognition and treatment.

Building and sustaining a secret sexual basement involves ongoing patterns of behaviors, attitudes, and beliefs in which a partner in an intimate relationship attempts to maintain power and control over the other, through psychological and relational manipulation and deception – in other words, abuse. Someone who builds and sustains a secret sexual basement will often engage in repeated integrity violations, deceptive management, and psychological and relational manipulation, all of which constitute an ongoing system of harm. You see, we're not just talking about infidelity in terms of sexual acts that break a promise or emotional boundary violations. Deceptive sexuality is most accurately understood as an **ongoing form of domestic abuse**. And this key conceptualization is missing from most traditional clinical models. Most models focus exclusively on the infidelity or cheating yet fail to address the years of ongoing integrity-abuse patterns or to conceptualize them as abusive.

Further, these models and practitioners do not view those who create and maintain DCSRs as experiencing a form of mental disorder or abuse problem. Instead, the focus of traditional approaches is on the diagnosis of the sexual behaviors (compulsive or addictive), the lack of sexual control, the cause of the sexual behavior patterns, and the negative consequences experienced by the person who is sexually acting out.

The primary problems with traditional models include:

### Failure to recognize the abuse.

The first problem with traditional clinical models is that they don't acknowledge the patterns of emotional, psychological, and relational abuse perpetrated on intimate partners and families of those doing the sexual or relational acting out. Deceptive sexuality is indeed a particularly destructive form of intimate partner abuse and domestic abuse. Often, there are ongoing patterns of abuse that victims experience for years, the consequences of which are significant.

### Failure to recognize the trauma.

Traditional clinical models do not recognize or understand the trauma symptoms experienced by these partners and family members. Sadly, however, this type of trauma is pervasive, intensely distressing, and in need of timely and appropriate diagnosis and treatment. Traditional models have ignored these trauma-related symptoms, and few practitioners in the psychological field as a whole have a solid conceptualization of this type of trauma.

### Failure to recognize and support the victims.

In addition to not recognizing the trauma, many clinical models lack consciousness about the victims of deceptive sexuality. Traditional treatment models have either excluded partners and family members from clinical consideration or, even more damaging, have tended to misdiagnose them. Some models rely on general couples or sex therapy approaches, while others use victim-blaming interventions based on the traditional concepts of co-sex addiction and codependency. Partners are often "educated" that their responses and reactions are actually part of the relationship problem or are symptoms of a co-addiction that require treatment and management. Unfortunately, none of these approaches appropriately recognize, diagnose, or attempt to treat the victimization and specified trauma-related symptoms associated with deceptive sexuality.

*[1] Sociopathic (or antisocial personality disorder) refers to someone who shows a long-term pattern of antisocial behaviors and attitudes, including manipulation, deceit, aggression, and a lack of empathy for others.*

### Failure to identify a disorder.

The field frequently uses terms such as sex addiction, compulsive sexual behavior, out of control sexual behavior, and impulse control problem. But these terms do not attempt to describe any type of abuse problem, sociopathic behavior patterns, or conduct disorder. The field has clearly failed to recognize the presence and impact of deceptive sexuality as a type of disorder. There is no established awareness of an integrity-abuse disorder as the cause of the abuse / trauma. And there are no notable efforts put towards recognizing the role of a systemic abuse problem in causing significant trauma-related symptoms.

Unfortunately, abuse and trauma caused by deceptive sexuality are buried in the shadows of normalization, denial, and our collective lack of insight.

### This needs to change.

Abuse and trauma caused by deceptive sexuality must be researched and more deeply understood by psychological practitioners and clinical researchers. We must better understand so that we can develop effective diagnostic and treatment approaches that address both sexual behaviors and abuse patterns that result in experiences of short- and long-term trauma.

# What is the Deceptive Sexuality and Trauma Model?

Deceptive sexuality and trauma (DST) expands the understanding, diagnosis, and treatment of sexual acting-out disorders. The model emphasizes not only sexual and relational acting-out patterns of behaviors, but also the associated dynamics of perpetration, violation, and abuse of others. The model identifies deceptive sexuality as a form of domestic abuse and, in addition to considering the role of and the impacts on the perpetrator, focuses on those harmed by these dynamics and the consequent trauma and wounding that they experience.

DST represents a clinical step forward in the field and a significant advancement in the treatment of sexual acting-out disorders and intimate partner abuse. This model confronts the traditional and current models of treatment and brings a critical set of new arguments to the ongoing debate related to sex addiction and compulsive sexual behaviors. The model provides both a diagnostic and treatment method for sexual-relational behavioral disorders (sexual compulsivity and sexual acting-out patterns) as well as the associated dynamics of violation and abuse of human beings, stemming from underlying factors such as developmental trauma as well as personality and gender pathologies.

DST conceptualizes sexual-relational behavioral disorders on a spectrum of both compulsive and abusive conduct. A key part of this model is the concept of deceptive sexuality, which is a form of domestic abuse that involves an ongoing deceptive system of psychological and relational tactics, which is propelled by a psychology of covert domination and control and constitutes a clear, methodical, and organized form of systemic psychological, emotional, and relational abuse and dehumanization. The clinical and technical term for deceptive sexuality is compulsive-abusive sexual-relational disorder (CASRD). According to DST, deceptive sexuality (or CASRD) includes behaviors aimed at creating and maintaining a deceptive, compartmentalized sexual reality (DCSR).

DST revises the clinical paradigm of sexual acting-out behaviors in the following important ways:

**1. DST expands the traditional, single-concept diagnosis of either sex addiction, compulsive sexual behavior or infidelity to include two primary criteria and symptoms: compulsive-entitled sexuality and integrity-abuse disorder.**

**Compulsive-entitled Sexuality (CES).** DST recognizes the role of sexual entitlement as a major factor that contributes to problematic sexual behavior patterns. Compulsive-entitled sexuality (CES) refers to an inability or an unwillingness to control sexual urges or behaviors, even when they cause significant negative consequences. In addition to being a main driver of problematic sexual behavior patterns, CES also plays a big role in abusive behaviors such as lying, deception, and psychological manipulation. *Examples of CES include problematic patterns of pornography, infidelity, prostitution, cybersex, and flirting. Sometimes CES can include clinical concerns such as sexual offending, abuse of power in the workplace, etc.*

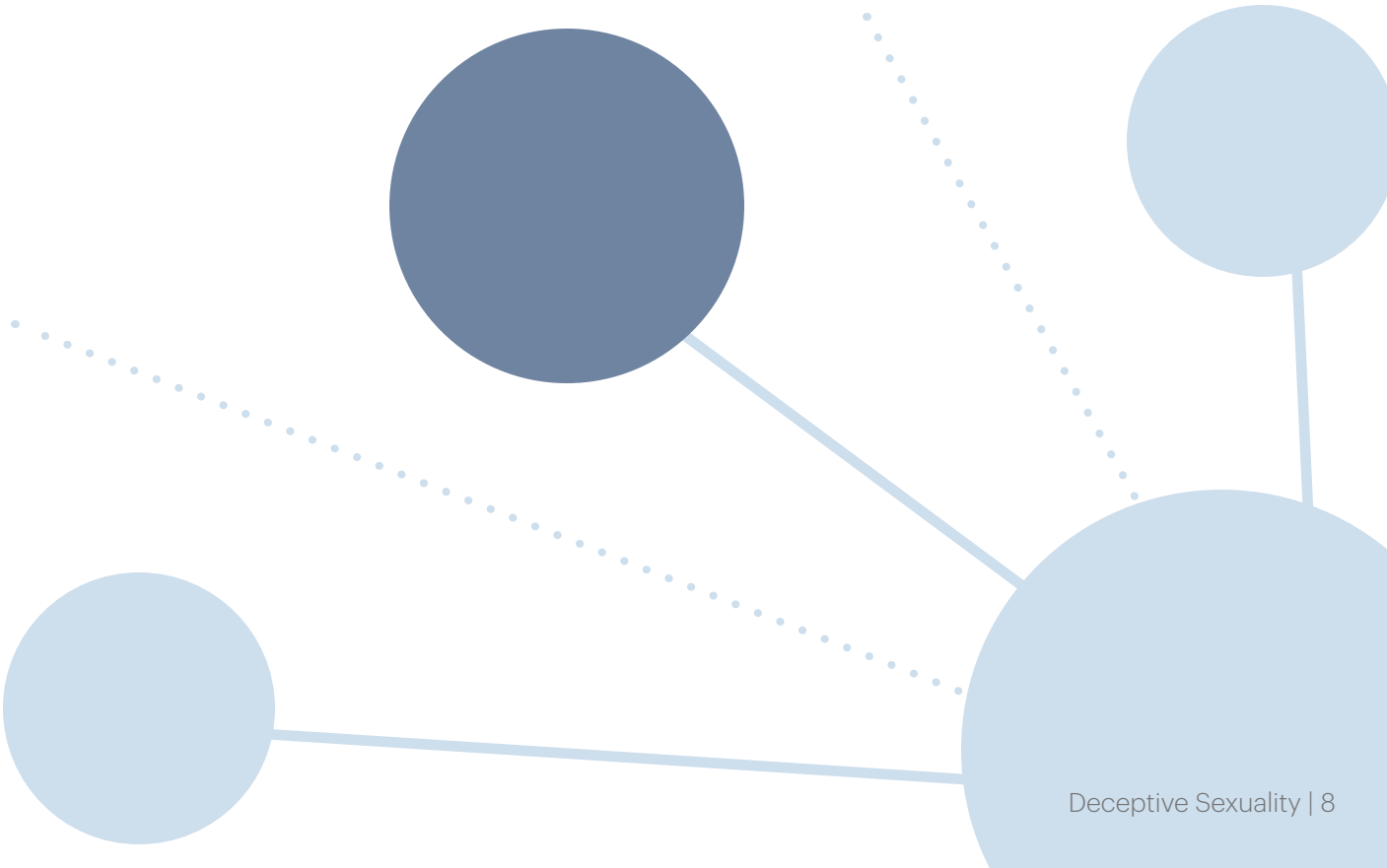
**Integrity-abuse disorder (IAD).** DST also gives attention to the roles that conduct disorder and covert psychological and relational abuse behaviors play in sexual acting-out behaviors and considers these pathological behavioral patterns to be a type of integrity-abuse disorder (IAD). IAD is a type of conduct disorder that is defined by a significant lack of integrity and a covert relational abuse system of domination and control. DST proposes that the abusive, deceptive, and manipulative behaviors that happen within an intimate relationship and in combination with sexual acting-out problems meet criteria for a type of conduct disorder, a type of sociopathic behavioral patterns known as integrity-abuse disorder, or IAD.

IAD is characterized by sociopathic patterns and antisocial personality characteristics and behaviors such as:

- a long-term pattern of disregard for, or violation of, the rights of others
- a demonstrated lack of empathy toward others
- deception and manipulation of the truth
- psychological manipulation of others (gaslighting)
- exploiting others for personal gain or pleasure through superficial charm, seduction, or intimidation
- deficits in conscience, integrity, and/or morality
- impulsivity and reckless behaviors
- a lack of remorse; callous attitude towards people harmed
- system of covert domination and control

These types of behavior patterns, referred to as integrity abuse (IA), can lead to repeated harm and abuse within relationships, particularly with intimate partners and family systems.

**2. DST identifies intimate partners and family members of people who engage in deceptive sexuality, who are subjected to patterns of both CES and IA, as victims of abuse who often experience trauma and stressor-related symptoms.** DST proposes that CES and IAD cause individuals to sexually act out in ways that lead to significant traumatic injuries for their victims. Importantly, the model recognizes that in such situations, systemic abuse problems exist in addition to sexual conduct issues. As such, this model shines a light on the abuse-victim dynamic that so frequently occurs, but is often overlooked, in these situations. The model challenges the codependency view that has often been associated with the single-concept diagnosis of co-sex addiction as well as other perspectives that may inadvertently blame the relationship or the intimate partner. DST replaces existing victim-blaming models with abuse-trauma consciousness and abuse-trauma-based treatment approaches. It is important that the abuse is addressed, but also that the victims are recognized and provided clinical care and indicated treatment as part of their clinical management. Further, this model replaces existing victim-blaming models with abuse-trauma awareness and treatment approaches. As such, the model is systemic and relational, utilizing a "three plates spinning" metaphoric concept that includes the acting-out-abusive partner, the intimate partner / spouse, and the relationship as a separate, third entity. The model asserts and emphasizes the importance of clinical coordination between all three entities (or "plates").



# What is Deceptive Sexuality Trauma (DST)?

Deceptive sexuality often involves the victimization of others through entitled sexuality and patterns of psychological, emotional, and relational abuse. The DST Model proposes that CES and IAD cause individuals to behave in ways that are abusive, that prohibit partners from being able to respond in healthy ways based on being informed about their reality, and that lead to significant traumatic symptoms and injuries for partners and family members. Deceptive sexuality trauma (DST) is a psychological term that describes both the traumatic injuries and the trauma symptoms caused by deceptive sexuality. According to this model, deceptive sexuality – and associated patterns of psychological deception and manipulation – represent a specific type of system of abuse that causes a specific type of trauma.

Understanding the specific type of trauma that victims of deceptive sexuality experience requires a description and basic knowledge of both post-traumatic stress and complex trauma, as victims of deceptive sexuality often experience symptoms related to both.

**Acute Trauma – Post-traumatic Stress.** Post-traumatic stress involves a single or distinct event or traumatic incident, which results in symptoms of intrusions, avoidance or constrictions, and hyperarousal. Many partners and family members of those who engage in deceptive sexuality develop symptoms that meet most of the criteria for post-traumatic stress-related symptoms, including:

- exposure to extreme stress
- intrusive re-experiencing
- frequent episodes of triggering and reactivity associated with hyperarousal and hypervigilance
- persistent avoidance
- negative alterations in both thoughts and mood
- anxiety about potential disease and contamination
- worries about child safety
- social isolation
- significant embarrassment and shame
- intense relational rupture and attachment injuries

Acute post-traumatic stress often occurs around the time that a partner finds out about the sexual acting-out behaviors.

**Ongoing Systemic Trauma – Complex Post-traumatic Stress.** Complex post-traumatic stress, or what is referred to as complex trauma shaping (CTS), involves patterns of harm that exist over a period of time and in the context of disempowerment or the lack of a viable escape route. These experiences shape a person's psyche over time, like drops of water on a rock. CTS is a process that gradually develops in response to the long-term progressive patterns of psychological, emotional, and relational harm that are associated with sexual acting-out behaviors and integrity-abuse patterns. Many partners and family members of those who engage in deceptive sexuality also develop symptoms of complex trauma, which gradually develop in response to the long-term progressive patterns of psychological, emotional, and relational harm associated with deceptive sexuality.

Complex trauma symptoms can include progressive negative alterations to:

- emotions and how a person copes with emotions
- thoughts, distortions in thoughts to cope, lack of thoughts, thinking, consciousness
- self perception, self-contact and awareness, self-esteem
- how the person makes meaning in their psyche
- how the person relates to other human beings and attachment functions
- perceptions of the abuser, abuse, and how the person relates to violence

Deceptive sexuality CTS injures core parts of identity and self-functions, including wounding to:

- a person's survival instincts and their ability to depend on their second brain
- sexuality, sexual identity, sexual esteem, and sexual functions
- gender, gender identity, gender esteem, and gender functions
- the physical body, body image, physical appearance, and body-related thoughts and emotions

CTS as a result of deceptive sexuality may also impact relationships, injure attachments, and negatively alter interactions with, and trust in, other people. For example, DST may negatively impact:

- a person's reliance on their intimate partner due to relational integrity erosion and relational rupture during the exposure phase
- children and the family system, including the parent-child bond
- a person's sense of community, social functions, and presence in public
- one's spiritual beliefs

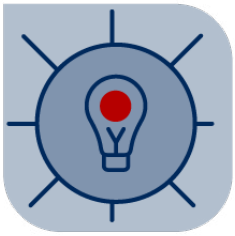
# The Three Phases of Deceptive Sexuality Trauma

Before we talk about the phases of DST, it's important to understand the concept of pre-existing reality-ego, or PRE. The term ego here simply refers to the reality of the self, or the subjective sense of self, which is separate from the rest of reality. We all experience an internal reality, or a reality of the self, as well as a sense of reality outside the self. The term reality-ego refers to both these realities and their interrelationship. The term pre-existing refers to a person's reality prior to the realization of a new reality. In the case of a DCSR, the PRE refers to everything that the partners and family members thought was real about their lives prior to discovering or becoming aware of the DCSR's existence.

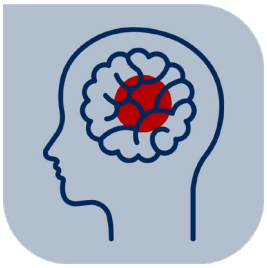
In the metaphor of the secret basement underneath the family home, the PRE would refer to the deceived family members' concept and understanding of their reality as a home without a basement. The PRE refers to everything that the family members thought was real about their lives prior to discovering or becoming aware of the basement's existence. Within the context of a DCSR, the PRE represents the partner's and family members' realities before they became aware of the DCSR.

Deceptive sexuality trauma (DST) is clinically organized into three phases:

**Covert Phase.** The covert phase of DST is defined as the phase prior to the exposure of the person's PRE to the DCSR. It refers to the period of time during which there exists a secret sexual basement, but it remains undiscovered. This is a phase of covert domination and control as well as eroding relational integrity and relational health. During the covert phase, complex trauma starts to take form within its victims, progressively shaping emotional and cognitive systems, constructs of self and self-esteem, relations with others, and systems of meaning. There can be ongoing damage to the enteric systems or gut instincts, causing second brain injuries to those impacted.



**Exposure Phase.** During the exposure phase, the partner's PRE collides with the DCSR – their previous perceptions of reality are exposed to the secret sexual basement underneath the relationship and family home. It is at this point that the discovery and awareness of the DCSR begins, and the partner's previous perceptions of reality are injured and forever altered. More specifically, the person loses their sense of reality about the world in general, their understanding of their partner, the nature of their relationship, and the authenticity of their attachment. It is during this phase when partners and family members begin to experience post-traumatic stress-related symptoms.



**Symptom Progression Phase.** The symptom progression phase of DST occurs after the exposure phase and the initial, acute post-traumatic stress-related symptoms. The symptom progression phase is defined as both the short-term and long-term impacts and symptoms that occur in the aftermath of the covert and exposure phases that may negatively impact all aspects of the partner's life. This phase focuses on core wounds related to identity, sexuality, gender, attachment, and relationships as well as the post-fragmentation reconstruction processes of ego, self, and reality. It may be during this phase that we start to see the net effects of the integrity abuse and the complex trauma shaping (CTS) arise and continue as the acute phase of post-traumatic stress-related symptoms may stabilize, recede, or decrease in intensity and/or frequency. The symptoms that are experienced in this phase may be deeper and may take longer to heal and repair than post-traumatic stress-related symptoms.

*The types of behaviors and conditions commonly associated with each of these phases are shown in the table on the next page.*

# Integrity-abuse Disorder (IAD): Behaviors, Patterns, and Conditions

## Covert Phase Integrity Abuse

- Lying/lying by omission
- Blaming
- Deceiving, hiding, manipulating the truth
- Gaslighting (intentional psychological manipulation of the victim's reality)
- Enteric system (second brain) incongruence (two separate realities exist)
- Covert or overt blaming the intimate partner or relationship
- Cultivating negative narratives in order to justify DCSR (corroding perceptions of intimate partner, relationship, family system)
- Relational neglect, withdrawal, rejection (including sexual)
- Relational integrity erosion
- Relational (including family) risk-taking and endangerment
- Covert tactics of domination and control
- Intentional withholding of life-altering information necessary for survival (leaving victim in state of disempowerment, without a viable escape route)
- Intentional withholding of relevant information (e.g., about the DCSR) in treatment (individual or couples)

## Exposure Phase Integrity Abuse

- Lying/lying by omission
- Deceiving, hiding, manipulating the truth
- Gaslighting (intentional psychological manipulation of the victim's reality)
- Externalizing responsibility
- Blaming the intimate partner or relationship for the DCSR
- Denying the problem or the disorder and its actual consequences
- Continued sexual-relational violation behavior (overt infidelity or DCSR)
- Minimizing
- Rationalizing
- Justifying
- Projecting
- Denying
- Covering-up
- Partial disclosures
- Revising facts and history
- Obstructing
- Stonewalling
- Refusing to cooperate or to speak
- Technical manipulation
- Verbal abuse or diminishment
- Intimidation and threatening
- Being aggressive or passively aggressive
- Equivocating
- Withdrawing
- Abandonment
- Feigning innocence or ignorance
- Assuming the role of victim
- Fault-finding
- Demanding immediate equality
- Frequent or rapid integrity violations or abusive actions
- Shaping the narrative
- Defying logic or reason as a protective tactic
- Shifting focus to the abuser's pain
- Selective attention or memory
- Callous / cruel attitudes and actions towards victim
- Lack of demonstrated remorse
- Lack of demonstrated empathy
- Integrity abuse towards the victim (e.g., denying facts) in context of treatment (couples)

## Symptom Progression Phase Integrity Abuse

- Lying/lying by omission
- Deceiving, hiding, manipulating the truth
- Gaslighting (intentional psychological manipulation of the victim's reality)
- Externalizing responsibility
- Blaming the intimate partner or relationship
- Denying the problem or the disorder and its long-term consequences
- Demonstrating resistance to dealing with painful realities
- Violating agreements or commitments
- Inability or unwillingness to be accountable
- Refusing to participate in repair or healing
- Inability to provide valuable care or support
- Pathologizing the victim's reactions
- Demanding that the victim get over it and move on (demonstrated impatience)
- Sexual entitlement and demands (violations)
- Assumptions and expectations of impunity
- Callous and insensitive attitudes towards the victim
- Continued engagement of the DCSR
- Continued domination and control (covert and/or overt)
- Continued social misrepresentation
- Continued lack of demonstrated remorse or empathy
- Resisting, avoiding, prematurely terminating or abandoning treatment

# Critical Injuries of Deceptive Sexuality Trauma

During the three clinical phases of DST, victims may experience three critical injuries that cause trauma symptoms: reality-ego fragmentation, attachment rupture and injury, and enteric system second brain injury. Identifying these injuries helps to define and differentiate DST as a unique type of trauma and human experience. While there are many types of injuries related to DST, these three critical injuries consistently present and cluster together, making them specific and unique to this type of trauma.

1. The first critical injury is **reality-ego fragmentation** (REF), which occurs after the intersection between the victim's pre-existing reality-ego (PRE) and the DSCR (the Exposure Phase). This injury consists of damage and alterations to the person's perceptions of reality, which results in post-traumatic stress-related symptoms.

2. The second critical injury refers to **relational rupture and attachment injury.** This often occurs upon reality-ego fragmentation and results from the sudden rupture from, and loss of, attachment to the pre-existing partner. As is the case with the first critical injury, this injury causes specific post-traumatic stress-related symptoms.

3. The third critical injury involves **second brain injury** and results from complex trauma shaping of the person's enteric system and second brain, which injures a person's ability to rely on their gut instincts, causing systemic confusion due the incongruence between the primary and second brain. This second brain injury impacts the victim's relationships as well as their ability to effectively experience and respond to survival and adaptive instincts.

The full list of common traumatic injuries and symptoms of deceptive sexuality trauma include:

**Covert Phase (when the DCSR is intentionally kept a secret)**

1. Covert Phase Integrity-abuse Shaping
2. Erosion of Enteric System and Second Brain Injury
3. Erosion of Relational Integrity

**Exposure Phase (when the partner/family members find out about the DCSR)**

4. Exposure Phase Integrity-abuse Shaping
5. Discovery Trauma
6. Disclosure Trauma
7. Reality-ego Fragmentation
8. Acute Relational Rupture and Attachment Injury
9. Hypervigilance, Intrusions, and Persistent Re-experiencing
10. Avoidance of Trauma-related Stimuli
11. Negative Alterations in Thoughts and Mood
12. Trauma-related Arousal and Reactivity
13. Distress and Functional Impairment
14. Dissociative Symptoms

**Symptom Progression Phase (the aftermath; short- and long-term impacts)**

15. Symptom Progression Phase Integrity-abuse Shaping
16. Reality-ego Injuries and Reconstruction
17. Sexual Symptoms and Functioning
18. Gender Wounds and Symptoms
19. Persistent Negative Relational Patterns
20. Family, Communal, and Social Injuries
21. Treatment-induced Trauma

## Diagnostic Considerations

From a diagnostic perspective, exclusive reliance on the lack of control component of the problem is grossly inadequate. It disregards the potentially significant pathology that may underly the abusive patterns and require clinical treatment. Harm to self, others, and relationships as well as impacts on daily life functioning also require diagnostic consideration and treatment.

The Deceptive Sexuality and Trauma Model proposes that the diagnostic DSM-V conceptualization of sexual and relational acting-out behaviors may fall under the category of Specified Disruptive, Impulse-Control, and Conduct Disorder. This DSM-V diagnostic code refers to a broad umbrella category that describes a spectrum of disorders that potentially include three aspects of pathology: disruptive behaviors, impulse control, and conduct disorders. This conceptualization is aligned with the model's clinical understanding of deceptive sexuality as existing on a spectrum, with problems related to a lack of control and/or abusive sexual and relational conduct, often presenting with significant overlap between the two and resulting in significant harm to others. In addition, due to the DSM-V's PTSD diagnosis requirement that the traumatic injury be physical – and not psychological – the current DSM-V diagnosis for deceptive sexuality trauma may instead fall more accurately under the category of Other Specified Trauma and Stressor-related Disorder.

## Clinical Considerations

DST is unique in that it conceptualizes an abuse disorder and a specified type of trauma-related stress disorder in diagnosing and treating those affected by deceptive sexuality. This model has developed over time and in response to years of clinical work, with human beings – in relationship with people and their true real-life experiences, shared in their own voices.

The clinical management and treatment of this type of abuse and trauma requires specialized education and training. This is very important, given that "psychologists who do not have the requisite training potentially endanger their clients and likely commit an ethical violation" (Intimate Partner Abuse and Relationship Violence Working Group, 2001, p. 5).

The following list includes important clinical considerations based on the Deceptive Sexuality and Trauma Model:

- Deceptive sexuality usually includes ongoing patterns of behaviors, attitudes, and beliefs in which a partner in an intimate relationship attempts to maintain power and control over the other through psychological, relational, and sexual deception and manipulation.
- Deceptive sexuality usually produces fear and trauma in those being victimized.
- Deceptive sexuality includes chronic patterns of relational perpetration, emotional abuse, psychological manipulation, attachment injury and violation, and sociopathic behavioral patterns (i.e., integrity-abuse disorder), as well as problematic, compulsive sexual and/or sexually entitled behavioral patterns, all of which must be clinically addressed and treated.
- Treatment for deceptive sexuality should be informed by consciousness of an abuse dynamic, an abuser, and a victim(s), not just a sexuality problem or a moral problem.
- The impact of deceptive sexuality often results in deceptive sexuality trauma (DST), which is the trauma that results directly from the impact of the integrity-abuse disorder and compulsive-entitled sexuality.
- DST often impacts the domestic sphere – the intimate partner, the couple, and sometimes children and the family system.
- DST often presents within the partner and the relationship as a combination of both post-traumatic stress-related symptoms and complex trauma-related symptoms.
- DST can be conceptualized as an Other Specified Trauma and Stressor related Disorder, which includes both post-traumatic stress-related and complex-trauma symptoms and requires clinical treatment.
- The Deceptive Sexuality and Trauma Model recommends systemic and relational treatment approaches and case conceptualization when indicated. The person engaging in the deceptive sexuality, the intimate partner, and the couple should be seen as three separate entities. Without careful clinical coordination between all three entities (as opposed to a compartmentalized approach), each component may be potentially compromised.
- It is important to recognize unconscious biases, consider context, and avoid pathologizing patients in treatment. Literature shows that specific diagnoses have been problematically applied to women and/or girls – including but not limited to histrionic and borderline personality disorders – without consideration of critical contextual factors. For example, as noted by the APA in 2018, " experiencing events punctuated by high levels of betrayal and trauma... are associated with characteristics of borderline personality disorder" (American Psychological Association Girls and Women Guidelines Group, 2018, p. 15).

# Glossary of Terms

| | |
|---|---|
| Complex Trauma Shaping | **CTS** |
| Compulsive-entitled Sexuality | **CES** |
| Deceptive, Compartmentalized, Sexual-relational Reality | **DCSR** |
| Deceptive Sexuality Trauma | **DST** |
| Deceptive Sexuality Trauma Treatment | **DSTT** |
| Integrity Abuse | **IA** |
| Integrity-abuse Disorder | **IAD** |
| Pre-existing Reality-ego | **PRE** |
| Reality-ego Fragmentation | **REF** |

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