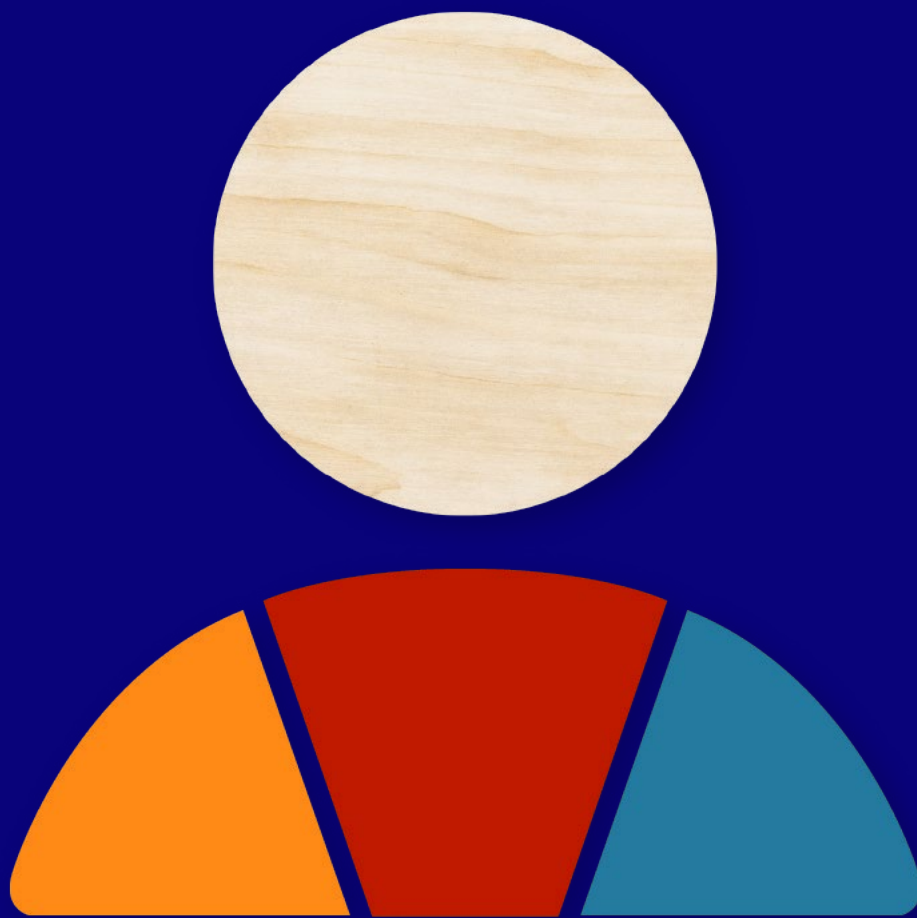


The Secret Sexual Basement:

*The Traumatic Impacts of Deceptive Sexuality
on the Intimate Partner and Relationship*



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February 2021 (revised November 2021)

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Note from Dr. Minwalla

Dear Reader:

“The Secret Sexual Basement” is a metaphor to help us better understand the concept of a deceptive, compartmentalized, sexual-relational reality (DCSR) in the context of an intimate relationship(s) or family system. It represents a person’s deceptively hidden sexual, romantic, and/or emotional intimacy with others that is not shared with the primary intimate partner.

This paper discusses deceptive sexuality – a specific type of abuse problem – and the trauma-related experiences and symptoms of people impacted by it. The intent of this paper is to serve as a helpful resource for people who may be experiencing these problems (abusers and victims), as well as for healthcare professionals who are seeking knowledge on how to best respond to and treat clinical presentations associated with deceptive sexuality. My own learning as a mental health professional has come about, in large part, through a process of sitting in rooms with victims of deceptive sexuality – with intimate partners and spouses who have been abused and traumatized in a very specific way – as an empathic witness, listening to and hearing their traumatic realities, with an open mind and heart. This paper was written as a synthesis of their voices – of the human beings living through and harmed by these experiences. This paper is very much for them – the people suffering – and was written with them in mind, and in my heart. With this type of abuse and trauma still lying in our collective darkness, it’s my hope, particularly for victims but very much also for abusers, that this paper may serve as a lighthouse that gives people hope and support as they attempt to survive.

Reading clinical perspectives on abuse and trauma, particularly if these issues are personal, may bring about emotional and psychological reactions that are upsetting, challenging, and sometimes overwhelming. Therefore, it is important that you be mindful of time, place, context, intention, and purpose as you read this paper. The content should be taken in and absorbed in a way that recognizes, appreciates, and honors your unique reactions to the material and the impacts that the material may have on you. Importantly, the information in this paper should be read and metabolized slowly, over time – this paper is not intended to be read in one sitting.

Sincerely,
Dr. Omar Minwalla

About Dr. Minwalla and the Deceptive Sexuality and Trauma Model

Dr. Omar Minwalla first studied sexual trauma among partners in 2005. He collaborated with Silvia Jason, MFT, CSAT, who articulated the initial dimensions of the partner trauma concept and highlighted the salience and prevalence of emotional abuse and gaslighting in sex addiction-compulsivity (Jason, 2009). Using Dr. Minwalla’s initial research along with Silvia Jason’s initial dimension articulation, Dr. Minwalla and Silvia Jason created and conducted workshops together and carried out research to further develop the trauma model (Jason & Minwalla, 2008). Dr. Minwalla and the Institute for Sexual Health (ISH) then went on to further develop the term sex addiction-induced trauma (SAIT) and the thirteen dimensions of sex addiction-induced trauma among partners and spouses through direct clinical application and grounded-theory research methodology (Minwalla, 2012a). Dr. Minwalla then continued the evolution of the model (now known as the Deceptive Sexuality and Trauma Model) by developing the terms “integrity abuse” and “deceptive sexuality” and by integrating these concepts, as well as domestic abuse and gender pathology, into the model.

Dr. Minwalla would like to acknowledge Silvia Jason, MFT, CSAT for her early contribution to the model, the ISH clinical staff for the application and further development of the treatment model, and especially all the people who have shared their experiences in an attempt to heal.

Deceptive Sexuality

Deceptive sexuality refers to problematic sexual behaviors in combination with associated patterns of domestic and intimate partner relational abuse that frequently lead to traumatic injuries. Abuse usually includes an ongoing pattern of behaviors, attitudes, and beliefs in which a partner in an intimate relationship attempts to maintain power and control over the other through the use of psychological, physical, and/or sexual coercion. Abuse usually produces fear and trauma in those being victimized (Intimate Partner Abuse and Relationship Violence Working Group, 2001).

The Deceptive Sexuality and Trauma (DST) Model

The Deceptive Sexuality and Trauma (DST) Model expands the understanding, diagnosis, and treatment of sexual acting-out disorders beyond the scope of traditional models. It 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 behavior disorder. Importantly, the model and its components are derived from both grounded qualitative research and direct clinical application...indeed, the model has been developed by including the victim's perspective – **from the bottom looking up, not just from the top looking down**. The DST Model identifies deceptive sexuality as a form of domestic abuse and revises the clinical paradigm of sexual acting-out behaviors in at least three important ways:

- 1.** The DST Model expands the traditional, single-concept diagnosis of either sex addiction or compulsive sexual behavior to include sexual entitlement, thus deriving **compulsive-entitled sexuality (CES)** as a major factor that contributes to problematic sexual behavior patterns. CES refers to an inability or an unwillingness to control sexual urges or behaviors, even when they cause significant negative consequences. *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.*
- 2.** The DST Model 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 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. 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 (Simon, 2011), integrity, and/or morality
 - impulsivity and reckless behaviors
 - a lack of remorse; callous attitude towards people harmed
 - 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.

- 3.** The DST Model identifies intimate partners and family members of people who have engaged in deceptive sexuality, who are subjected to patterns of both CES and IA, as victims of abuse who often experience devastating trauma symptoms. 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 (Carnes, 1991) as well as other perspectives that may inadvertently blame the relationship or the intimate partner (Minwalla, 2012b).

The DST Model proposes that compulsive-entitled sexuality (CES) and integrity-abuse disorder (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, abuse problems exist in addition to sexuality issues. Further, this model replaces existing victim-blaming models with abuse-trauma awareness, consciousness, and trauma-based treatment approaches (Minwalla, 2011a, 2012b).

Deceptive Sexuality Trauma (DST)

Deceptive sexuality trauma (DST) is a psychological term that describes both the traumatic impacts and the trauma symptoms caused by the deceptive sexuality. According to this model, **deceptive sexuality – and its associated patterns of psychological deception and manipulation – represents a specific type of abusive conduct that causes a specific type of trauma.** And understanding the specific type of trauma that victims of deceptive sexuality experience requires a description and basic knowledge of both post-traumatic stress disorder (PTSD) and complex trauma (C-PTSD), as victims of deceptive sexuality often experience symptoms related to both.



Important Distinction: *Deceptive sexuality trauma (DST) refers to the direct impacts of patterns and behaviors related to CES and IAD, not to developmental or childhood trauma that may have been previously experienced by the victim. This is an important distinction. Developmental or childhood trauma is not the same as DST. DST is a clinical term that describes specific traumatic symptoms that result from patterns of abuse and injurious experiences associated with being a victim of deceptive sexuality.*

PTSD 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 individuals who have engaged in deceptive sexuality develop symptoms that meet most of the criteria for PTSD-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

Some experience:

- 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, also known as the deceptive, compartmentalized, sexual-relational reality (DCSR).

In this model, **C-PTSD** (Herman, 1997), 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 abuse patterns. CTS can include progressive negative alterations to:

- emotional functioning, thoughts, self-perceptions, and esteem
- relational and attachment functions
- perceptions of the abuser
- how the person relates to other human beings, their lives, and/or their realities

Complex trauma may also impact a person's survival instincts and erode their ability to depend on their second brain. This type of trauma may also negatively impact physical, sexuality, gender, relational, and social functions.



Keep in Mind: *Complex trauma shaping (CTS) is a term that is based on the principles and processes of complex trauma (Herman, 1997). However, in the Deceptive Sexuality and Trauma Model we conceptually extend and expand the description of complex trauma symptoms by defining each symptom cluster in broader terms and by including more normative and less severe forms of harm.*

Two Key Concepts of Deceptive Sexuality

Before we move forward, it is important to define and clarify two key concepts associated with deceptive sexuality: deceptive, compartmentalized, sexual-relational reality (DCSR) and pre-existing reality-ego (PRE).

Deceptive, Compartmentalized, Sexual-relational Reality (DCSR). A person's secret sexual or romantic life can be referred to as a deceptive, compartmentalized, sexual-relational reality...or DCSR for short. It represents a person's deceptively hidden sexual, romantic, and/or emotional intimacy with others that is not shared with the primary intimate partner.

A metaphor might be useful in helping to understand DCSR:

Imagine a home where all members of a particular family reside. They live happily within the home, with its two bedrooms and two bathrooms, spanning two floors. They make dinners together in the kitchen and store their sporting goods in the garage. But what they aren't aware of is that this happy home includes a secret basement down below. In reality, there exists an entire hidden basement to this home...a basement full of secrets and activities, that only one member of the family knows about.

This family member created and maintains this hidden basement. He or she enters it to engage in secret sexual behaviors and to connect and interact with other people in a sexual, romantic, and/or emotional manner. Further, when this family member goes into the basement, they become a person who the rest of the family would never recognize in terms of their values, thoughts, feelings, and attitudes. This person becomes unrecognizable because they act in ways that are in stark contrast to how they behave and represent themselves when they are in the home with their family.

We need to realize that there is a lot more in the basement besides just sexual behaviors. In fact, it's a large space filled with a whole reality that is unknown to others. When we talk about a DCSR, we are not simply referring to sexual or relational behaviors or acts. We are not only describing, for example, a person's secret use of porn, sex acts with prostitutes, or emotional connections with colleagues. A DCSR may also include interactions and conversations with other people and activities such as walking, eating, driving, spending money, and so on, and also includes the person who built it and engages in it. Indeed, many victims and perpetrators alike describe the sexual-relational reality as living a "double life" or being in a "separate, sexualized universe." It is a reality.

Pre-existing Reality-ego (PRE). The second concept that is important for us to discuss is referred to as a PRE, or the person's pre-existing reality-ego. 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.

Three Phases of Deceptive Sexuality Trauma (DST)

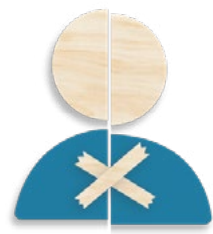
Deceptive sexuality trauma (DST) is clinically organized into three phases:




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-existing reality ego (PRE) collides with the DCSR – the 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 PRE is injured and forever altered. This process represents a specific psychological injury that is referred to as reality-ego fragmentation (REF). 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 PTSD-related symptoms.



Symptom Progression Phase. The symptom progression phase of DST occurs after the exposure phase and the initial, acute PTSD-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 PTSD 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 PTSD-related trauma symptoms.

 **Keep in Mind:** *The three phases of DST are not necessarily experienced by people in distinct stages or a linear order. The stages often overlap and fluctuate, and the transition between one stage and the next is frequently not a direct line of transition. Symptoms may appear in unique and different ways and may not precisely match the three phases as described here.*

Traumatic Injuries and Symptoms of Deceptive Sexuality Trauma (DST)

Covert Phase (when the PRE and DCSR are intentionally kept separate)

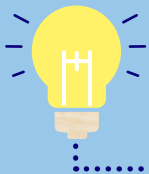
1. Covert Phase Integrity-abuse Shaping
2. Erosion of Enteric System and Second Brain Injury
3. Erosion of Relational Integrity

Exposure Phase (when the PRE and DCSR intersect)

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)

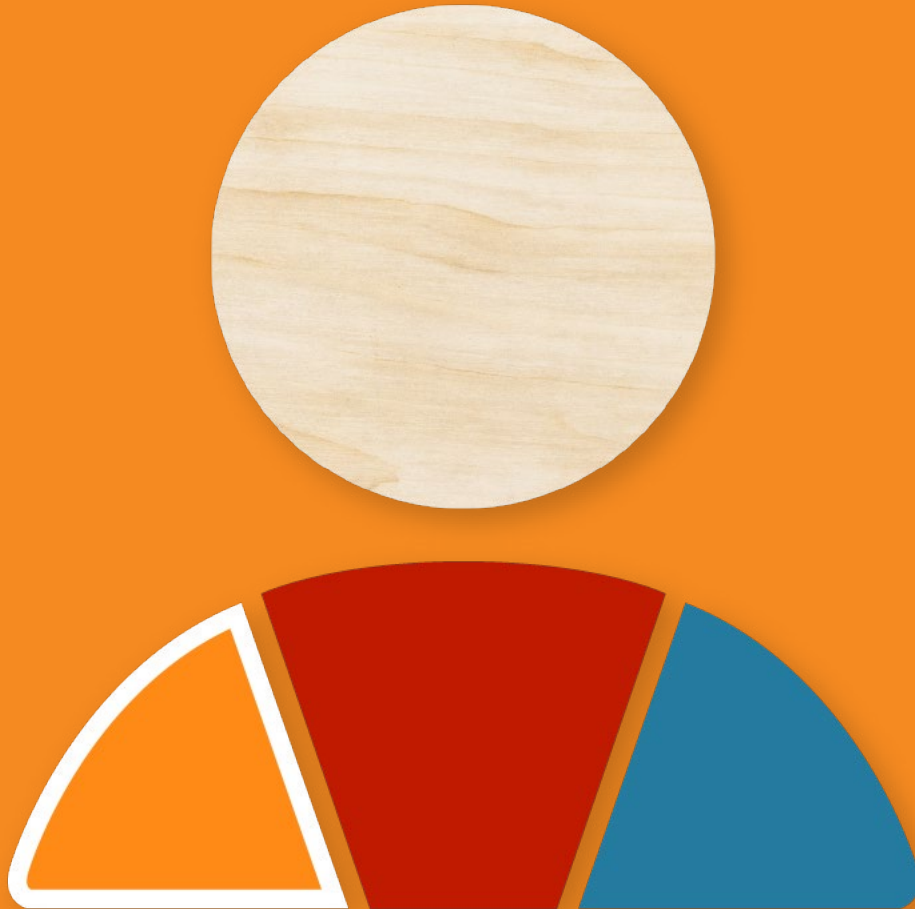
15. Symptom Progression Phase Integrity-abuse Shaping
16. Reality-ego Injuries and Reconstruction
17. Sexual Symptoms and Functioning
18. Gender Wounds and Symptoms
19. Persistent Negative Relational Patterns
20. Family, Communal, and Social Injuries
21. Treatment-induced Trauma



Remember: *The traumatic experiences and symptoms described within each phase should be understood as occurring in an environment of ongoing psychological, emotional, and relational abuse and harmful patterns and events - the integrity abuse (IA). It is important to remember that not all dimensions, impacts, injuries, and symptoms may be relevant for every partner or spouse.*

Covert Phase

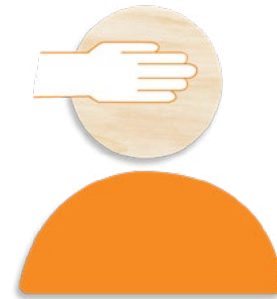
Living on Top of the Secret Sexual Basement without Knowing It



- When the pre-existing reality-ego (PRE) and the deceptive, compartmentalized, sexual-relational reality (DCSR) are intentionally kept separate
 - An ongoing system of covert domination and control
- Involves complex trauma shaping (CTS) of the victim(s) and the relationship
- Includes erosion of second brain and relational integrity

1. Covert Phase Integrity-abuse Shaping. Covert phase integrity-abuse shaping refers to the integrity abuse that occurs during the covert phase of DST. During this phase, partners often don't realize what's happening to them - they are not aware that the secret sexual basement exists. This lack of information leaves them effectively disempowered and without a viable escape route. Integrity-abuse behaviors and conditions during this phase include:

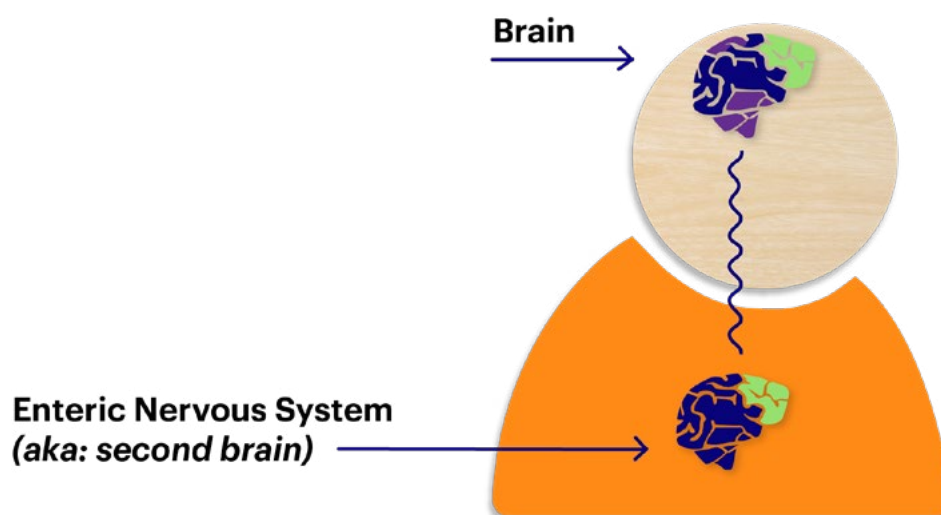
- lying/lying by omission
- deceptive tactics and manipulations
- blaming the partner or relationship
- intentional psychological manipulation of victim's reality
- withdrawal and neglect
- endangerment
- corrosive narratives in order to justify



Under such conditions, this phase constitutes a form of covert domination and control of a human being(s). The ongoing behaviors and conditions that take place during the covert phase cause serious psychological, emotional, and relational trauma that can lead to both short- and long-term psychological, emotional, and relational symptoms.

2. Erosion of Enteric System and Second Brain Injury. During the covert phase, partners are likely to detect (consciously or subconsciously) threats in their environment; they are likely to subtly detect the presence of a secret sexual basement, even though they are not aware of it on a conscious level. However, these individuals often are not sure about where these feelings originate from. There is a fundamental incongruence between the victim's gut instincts and their partner's definitions of reality. As a result, victims may experience confusion and chaos. They may struggle to understand what is happening to them and to make sense of their second brain signals and survival impulses.

In addition, partners are often gaslighted by their abusers (Jason, 2009; Jason & Minwalla, 2009). Gaslighting (Dorpat, 1994, 1996; Gass & Nichols, 1988) is the process in which the abuser intentionally manipulates their partner's reality in order to protect reality and the truth from becoming known or discovered by their partner (Jason, 2009). If the victim decides to trust their partner's definitions of reality, the victim learns (over time) to distrust and ignore their healthy survival gut instincts. The victim loses their ability to depend on their internal system of detecting threats and propelling instincts to survive. In addition, they may eventually become generally hypervigilant and distrusting. Sometimes victims even become reliant on the perpetrator's reality and use it as an adapted "survival instinct." If the ability to utilize one's own intuition is so compromised and abused and/or if the victim has been manipulated into deep dependency and reliance on the perpetrator's definition and mandate of reality, then the victim may not be able to generate or act on emancipation impulses (so the idea of "just leaving" is not reality-based for some partners).



3. Erosion of Relational Integrity. Relationship integrity refers to the honesty, truthfulness, and authenticity that each partner brings to a relationship. Relationship integrity plays a huge role in determining how whole or complete a relationship is able to be. Relational integrity is not simply a belief in each person's mind, but an actual reality that exists between two people and separate from each person's individual evaluation or assessment of that reality. The theory of relational integrity proposes that integrity is part of an energetic system that exists between human beings. This theory states that the degree of authenticity and truth expressed between two people creates an energetic system between them. Within this system, each person transmits an energy that is associated with the degree of truth, authenticity, and transparency that they bring to the relationship. The energy submitted by each person, in turn, creates a type of relational energy between the two individuals that plays a big role in determining the integrity of the relationship. The idea of having "a nice flow," "good energy," or "good vibes" in a relationship may be descriptions of this energetic system of openness and honesty that exists or is experienced in a relationship.

Unfortunately, when there is an ongoing system of deception or lies within a relationship, the person involved tends to emit specific types of energy waves that result in an imbalanced energetic system. A deceptive, compartmentalized sexual-relational reality (DCSR) negatively impacts a relationship's energetic system. More specifically, a DCSR fragments the energy that exists in the relationship and creates a different frequency that is highly incongruent with the energy of the system as a whole.

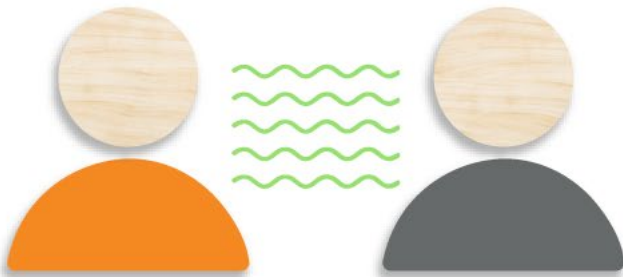
Often this damage is done to the relationship specifically, and by extension to each person as well (sometimes for many years), even before the partner learns of the DCSR/secret sexual basement. The damage can include symptoms such as:

- a sense of disconnection
- a decreased ability to absorb intimacy or love
- a weakening in the ability to depend on, or feel stabilized by, the relationship
- increased feelings of isolation and loneliness in the relationship
- fewer expressions of emotional nurturance
- an increased likelihood for avoidance – including avoiding sexuality and physical touch
- increased feelings of aversion and emptiness in the relationship

Relational Integrity

Definition of Relational Integrity: The degree of integrity or authenticity that exists between two people - an energetic system

High Relational Integrity "Good Vibes"



Description of High Relational Integrity:

- Transmission is optimal
- High frequency energy waves
- Congruence between waves
- Flow is harmonious

Optimal transmission allows for emission, transmission, and absorption by the other, permitting optimal sustenance to the relationship, which allows the relationship, and each person in it, to experience vital relational nutrients such as:

- Nurturance
- Care
- Support
- Love
- Dependency
- Security
- Respect
- Loyalty
- Positive regard
- Esteem

Low Relational Integrity "Not Feeling It"



Description of Low Relational Integrity:

- Transmission is weakened, diminished, eroded
- Low frequency energy waves
- Incongruence and interference of waves
- Flow is interrupted, clashes

The erosion of transmission leads to a decreased ability to absorb nutrients and may cause the following relational symptoms:

- Weakening of ability to depend on the partner
- Decreased security or stabilization in attachment
- Increased feelings of isolation within the relationship
- Fewer expressions of emotional nurturance
- Increased likelihood of avoidance (sexual, touch, time)
- Increased feelings of emptiness
- Increased feelings of aversion to the other and the relationship

Exposure Phase

*Discovering the Secret Sexual Basement
and the Abuser's Role in Building It*



- When the person is exposed to the secret sexual basement
 - Exposure occurs through discoveries and/or disclosures
- Involves post-traumatic stress symptoms coupled with integrity abuse
 - Includes reality-ego fragmentation (REF) and attachment injury
 - Can be experienced as a psychological “death”

4. Exposure Phase Integrity-Abuse Shaping. Exposure phase integrity-abuse shaping refers to the integrity abuse that occurs in the exposure phase of DST, during which the partner's pre-existing reality-ego (PRE) intersects with the DCSR. In this phase, the previous perceptions and structures of reality are exposed to the secret sexual basement. This process represents a specific psychological injury that is referred to as reality-ego fragmentation (REF). During the exposure phase, partners often experience intense, ongoing integrity abuse in the form of continuing patterns of emotional, psychological, and relational harm. The person who created and has been maintaining the secret basement will often try to defend themselves and to protect the truth from being exposed by utilizing specific defenses, often immediately after the initial discovery of the DCSR. The types of deceptive, manipulative, and defensive behaviors that occur in the exposure phase include:

- minimizing
- rationalizing
- justifying
- projecting
- denying
- covering-up
- lying/lying by omission
- presenting partial disclosures as full disclosures
- revising facts and history
- blaming
- obstructing
- stonewalling
- refusing to cooperate or speak
- twisting the truth
- getting angry
- threatening
- being aggressive or passively aggressive
- using forms of domination and control
- equivocating
- withdrawing
- feigning innocence or ignorance
- assuming the role of victim
- fault-finding
- gaslighting (psychologically manipulating)
- demanding immediate equality
- engaging in frequent or rapid integrity violations or abusive actions
- shaping the narrative
- defying logic or reason as a protective tactic
- using technical manipulation

Exposure to this type of ongoing integrity abuse often causes victims to suffer both acute traumatic experiences and progressive CTS.

5. Discovery Trauma. Discovery of a secret sexual basement is a critical traumatic incident (discovery incident) as well as an ongoing traumatic process (discovery trauma). The configuration of traumatic discovery experiences can vary (Steffens & Rennie, 2006). Discovery can be an initial awareness or a gradual development of consciousness, but is often a sudden and direct collision between the victim's pre-existing reality and the secret sexual basement. This collision may cause post-traumatic stress symptoms, which are often acute and progressive and can include shock and disbelief, a high degree of rage due specifically to the betrayal, extreme fear, hyper-vigilance, and trauma-based reactivity and survival responses.

The collision may also cause reality-ego fragmentation (REF), as structural and functional damage alters the victim's pre-existing reality. This destabilizing injury is threatening to the psyche and introduces fear into the psychological-relational system, including "flight," "freeze," or "flee" survival-based responses. The victim's pre-existing reality is altered from its original form forever, resulting in a psychological death experience. The shattering of the assumptive world by this betrayal can cause a grief response which includes traumatic grief, numerous secondary losses, and/or disenfranchised grief, which is any grief which is judged or minimized by others. Since no one has physically "died," the grief can seem ambiguous, and the loss may not be witnessed or recognized by others. Further, the betrayed may find themselves living with anticipatory grief – imagining the wreckage of their future – and grieving the potential loss of stability, relationship, etc. before such a physical or emotional separation has occurred.

A discovery does not in any way indicate that the partner has the full and complete awareness, understanding, or truth of the secret sexual basement. Instead, a discovery means the victim's pre-existing reality has been injured and changed, resulting in some degree of awareness. This may lead to questioning about the secret sexual basement, including inquiries to the full extent and nature of the basement, how and why it was built, and who is the person who built it and has access to it. The answers to these questions inform decisions related to survival moving forward and impact the ability to provide sufficient stabilization.

The victim has no way of knowing or confirming the extent and nature of the secret sexual basement. The truth of reality has been systematically denied and withheld from them. Upon exposure, the abusive partner's word is revealed as corrupt and is no longer a reliable source of information, so even if they disclose the entire truth immediately with remorse, the victim will have no way of confirming it. The victim may wrestle with traumatic imagination and questioning, and truth-seeking will take time and require a process for the victim to fully comprehend. This delay in finding a grounding truth often provokes feelings of severe panic, terror, horror, and/or helplessness.

To fully understand the impact of discovery trauma, we must also consider the integrity abuse that may occur around each discovery incident. The abusive partner may utilize different tactics and defenses than those that have been used in the covert phase. Integrity-abuse behaviors may even escalate at the time of the discovery trauma because that is when the abuser's defenses and attempts to prevent further discovery are at their peaks. Integrity-abuse behaviors at this time may include stonewalling, denying, lying, technical manipulation¹, dictating and controlling the narrative, gaslighting, and getting angry or defensive. In response to these behaviors, victims may experience reality-ego fragmentation and an acute state of post-traumatic stress (see Exposure Phase on page 13).

A victim often experiences multiple and various forms of discovery incidents and processes over time, sometimes over many years or decades. It is important to consider each discovery as a unique trauma-inducing event (Steffens & Rennie, 2006). To reduce the clinical conceptualization of discovery trauma to a singular traumatic episode is often diagnostically incomplete and dismissive of the reality and the experience of the victim. As with all traumatic incidents that are ongoing and repetitive, if there are many or frequent discovery episodes over time, then the discovery trauma may constitute a form of CTS of the victim, in addition to each event causing post-traumatic stress. Integrity abuse and reality-ego fragmentation may be experienced together and stored as one traumatic memory. How the abusive partner responds to the discovery, their responses and reactions towards the victim, and their treatment of the relationship during the exposure phase will impact the type and severity of the traumatic experience for the victim and the relationship.

Victims of discovery trauma within the exposure phase experience acute trauma in response to integrity abuse as well as ongoing trauma due to escalating or continued patterns of psychological, emotional, and relational abuse. It is essentially like "kicking someone when they're down," "adding insult to injury" and "putting salt on the victim's wounds." Abusing someone who is in the depth of traumatic experience and who has just experienced a psychological death increases injury to the victim and impacts their ability to experience post-traumatic survival, coping, treatment, and healing.

6. Disclosure Trauma. Disclosure is a specific type of discovery (Steffens & Rennie, 2006). A disclosure experience refers to incidents or processes, sometimes occurring over many years or decades, wherein the victim is told about some aspect of the DCSR (the secret sexual basement). The intersection of the victim's pre-existing reality (PRE) with the DCSR can lead to disclosure incidents and disclosure trauma. As with discovery, a victim will typically experience multiple disclosure events that are often delivered in harmful or abusive ways (e.g., angry disclosures, partial disclosures framed as full disclosures, staggered disclosures, resisting and refusing disclosures, defensive stalling, etc.).

Each disclosure incident has the potential to become a specific traumatic event, leading to traumatic reactions and processes that may last for many years. Disclosures can lead to sudden and extreme ego disintegration, and/or they can cause a subtle, slow dissolution of ego structures. It is important to assess and to understand how many disclosures have occurred over time and understand the experience as a series of traumatic exposures to integrity-abuse behaviors for the abuse victim (see Exposure Phase on page 13).

¹Technical manipulation refers to the attempt to use jargon, limited definitions, and/or technical rationale to avoid taking responsibility (e.g., "I said that I may have done that, I never said that I did..."; an abuser arguing that they did not engage in sexual relations because there was no intercourse)

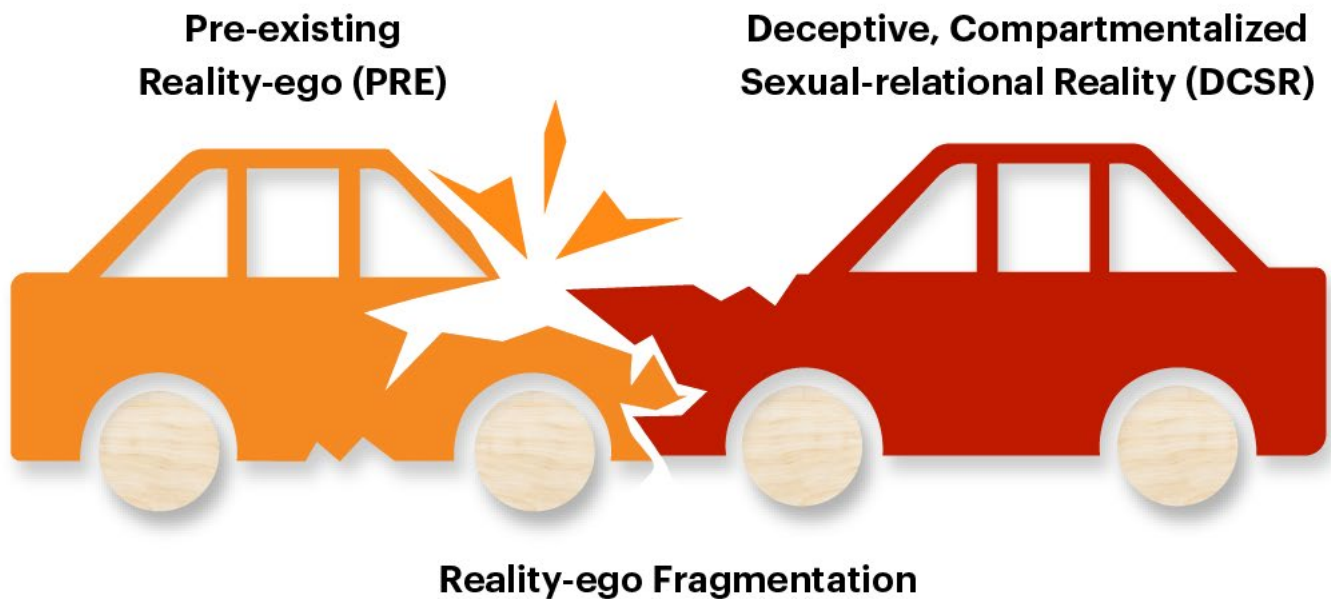
7. Reality-ego Fragmentation. Reality-ego fragmentation (REF) occurs when the PRE intersects with the DCSR. REF refers to psychological alterations that include a shattering of the ego (i.e., the self) and/or the inner reality. Within this clinical model, the term *ego* describes our subjective sense of ourselves – the aspect of experience that we describe as “me” or “I.” *Reality* is defined as our subjective experience of everything in totality. Thus, the term *reality-ego* refers to our entire sense of everything, our entire reality, including our sense of ourselves. Our ability to accurately perceive and effectively adapt to reality is essential for psychological health and stability.

The ego serves as a protective boundary between oneself and one’s environment. When two separate realities collide (as is the case in the exposure phase), the result is a process of de-structuring reality and progressively transforming the PRE. As someone goes through this process, their subjective experience of everything in their world is de-structured and transformed. It’s like waking up one day and feeling like a totally different person, with a completely new identity (Jason & Minwalla, 2009).

This process tends to be destabilizing, to say the least, and can lead to serious psychological injury. In fact, the reality-ego is itself traumatized and immediately or eventually fragmented. The injury to reality can lead people to feel weakened, shattered, and broken. Many people report feeling like their whole relationship has been a lie or a sham.

REF is often experienced as a sudden “psychic death,” a serious threat, or a significant injury that leads to post-traumatic symptoms. REF may be conceptualized as a psychic death because the victim’s global sense of reality, including their reality of themselves, is substantially fragmented and damaged by the exposure to the DCSR. The person’s PRE is essentially lost forever. It can never be reconstructed to exactly match how it existed before the intersection. Although it may be possible to repair, recover, and heal, the original PRE will never exist as it did before colliding with the DCSR. It is important to recognize the significant grieving process that comes along with this type of expansive psychological loss.

Critical Injury: Reality-ego Fragmentation (REF)



Post-traumatic Stress Symptoms:

- Hypervigilance, Intrusions, and Persistent Re-experiencing
- Avoidance of Trauma-related Stimuli
- Negative Alterations in Thoughts and Mood
- Trauma-related Arousal and Reactivity
- Distress and Functional Impairment
- Dissociative Symptoms

8. Acute Relational Rupture and Attachment Injury. Healthy and secure attachment to human beings is essential for psychological health. An attachment relationship is like a “psychological safety net to catch us if needed” (Johnson, 1996). When faced with life-threatening events, we typically seek our attachment partner for support as a survival instinct. On the other hand, disconnection from significant others often results in pain, dysregulation, and disease. When attachments are destroyed, the primal sense of safety and protection that had come from the attachments are lost (Johnson, 1996).

During the exposure phase, the rupture from what may have been previously experienced as a secure attachment, which included some level of psychological and emotional dependency, represents another critical traumatic injury. Because of the exposure to the DCSR, the person that the victim thought they knew and thought they could depend on is no longer there. This represents a sudden loss of the psychological safety net and causes a significant fall with no cushion. This type of relational rupture and attachment injury can lead to an inability to re-establish healthy or even regulatory attachments (Johnson, 1996) which, in turn, can result in dysfunctional reactions and an eventual loss of relational stability and basic dependency.

The attachment injury associated with the exposure phase clearly impacts the partner or spouse, but it often also profoundly impacts the relationship as a kind of separate, third entity. In other words, the relationship itself – the “us” – is traumatized. This type of relational trauma often causes significant symptoms and defensive coping adaptations in both partners. The significant instability in each person, and between each person, is a source of trauma, as are the numerous failed attempts at re-attachment. All of this causes notable injury to dependency and trust, further detachment, and, eventually, a form of complex trauma that continues to erode the relationship.

It is also important to note that during this process, the person’s previous protector – their “go to person” – has become a threat. In other words, the partner is the perpetrator and the threat from which the victim needs protection. So, rather than the instinctual turn towards that person, there is now a conflicting instinct to guard and protect against this abuser. These opposing instincts cause significant relational dysregulation, and the relationship becomes a trigger for each person within it. The victim often becomes terrified of the perpetrator. In addition, the abuser, who possibly also lost their PRE, their sense of attachment, and their psychological safety net, may also become fearful and triggered by the victim and the relational trauma. This can create a back-and-forth pattern of traumatic experience and seeking help from one’s partner, followed by attempts to escape and separate from the perpetrator.

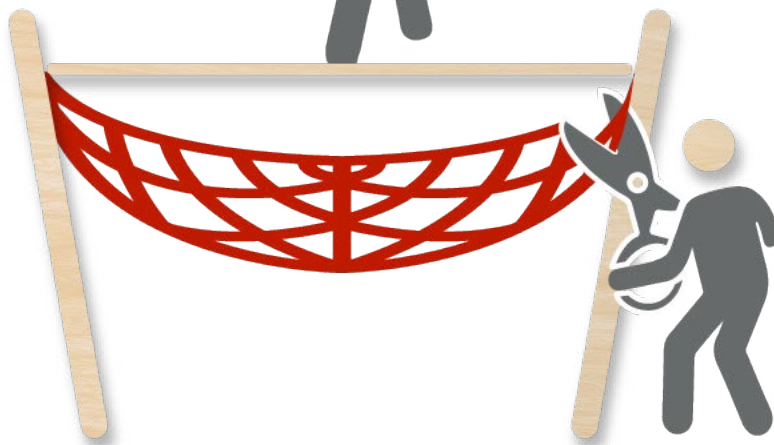
Go to Person is lost



- Go to Person is the person to lean on for help, support, and protection for survival and/or during times of crisis
- When that person cuts the safety net, they become a threat and no longer someone to go to for help, support, and protection

Safety Net is lost

- The Safety Net represents the psychological assumption of reliance and dependability during times of crisis
- The Safety Net is psychologically stabilizing
- The Safety Net is lost when the intimate partner discovers the DCSR



Exposure Phase Post-traumatic Symptoms

A traumatized, fragmented, and injured reality-ego causes notable functional impairment. When the ego function has been compromised, the result is an unbearable level of anxiety. Such wounding is often associated with primitive defense mechanisms such as splitting, trance states, switching among multiple centers of identity, or psychic numbing. When the ego fragments, one's inner world works to defend the traumatized psyche against further trauma. Although the ego seeks to repair itself by adapting and integrating, the victim's ability to effectively utilize their ego becomes compromised and diminished. Instead, their ego-reality fragments turn into traumatic memories, painful body experiences, and maladaptive coping patterns.

Reality-ego trauma and fragmentation can cause post-traumatic symptom clusters of:

- **Intrusions** (obsessions, flashbacks, nightmares, startle responses);
- **Constriction** (inhibiting thoughts, feelings, activities, numbing; induced dissociation) and/or
- **Hyperarousal** (fight or flight, hyper vigilance, safety-seeking behaviors, sympathetic activation/exhaustion systems).



Diagnostic Consideration: *The post-traumatic symptoms experienced during the exposure phase meet all but one criteria for PTSD as noted by the DSM-5: actual physical injury or death. The DSM-5 diagnosis of Other Specified Trauma/Stressor-Related Disorder (309.89) is the most accurate (current) diagnosis to describe REF in the DST exposure phase.*

9. Hypervigilance, Intrusions, and Persistent Re-experiencing. According to the Diagnostic and Statistical Manual of Mental Disorders (Version 5), PTSD is often characterized by heightened sensitivity to potential threats, including those that are related to the traumatic experience (American Psychiatric Association, 2013). Re-experiencing refers to situations in which the traumatic experience is "relived" and similar feelings and psychological states are experienced again by the person. Triggers are reminders or cues that activate memories that cause subjective "reliving" of the traumatic experience for the person. The DSM-5 describes the symptom of re-experiencing as including spontaneous memories of the traumatic event, recurrent dreams related to it, and/or flashbacks or other intense or prolonged psychological distress (American Psychiatric Association, 2013). It then also describes the symptom of arousal as being marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance, or related problems.

For intimate partners exposed to deceptive sexuality, triggers are often varied and seemingly endless due to the global and pervasive nature of the injuries. Triggers and re-experiencing of injuries related to the DCSR, reality-ego fragmentation, relational and attachment injuries, second brain activation, and confusion are quite common. Triggers and re-experiencing may also relate to the patterns of integrity abuse that they have suffered, such as lying, deceptive tactics, diminishment, dehumanization, and aggressive verbal abuse. In addition, the person who has created the DCSR and engaged in the integrity abuse can be a potential trigger for the victim, often causing significant relational disturbances. And when reality has been injured as it is in deceptive sexuality circumstances, then the new reality itself (which now includes the DCSR) can be a potential trigger. Many intimate partners report severe, disturbing, and intensely distressing symptoms of post-traumatic triggers and re-experiencing that often contribute to negative relational patterns that then create additional pain and stress.

10. Avoidance of Trauma-related Stimuli. Individuals experiencing this type of trauma often attempt to cope by avoiding and numbing their traumatic symptoms. Avoidance and numbing are strategies for coping with the psychological pain, confusion, horror, and disorientation as well as the intensely experienced distressing and overwhelming emotional, psychological, and relational disturbances and alterations that are associated with deceptive sexuality. Avoiding places, people, and situations that symbolize an aspect of the secret sexual basement and that are known to be triggers is common among partners impacted by this type of trauma. One form of avoiding is to numb, medicate, or find methods for blotting out pain, circumventing the intensity or severity of symptoms and decreasing the potential for re-experiencing. Individuals may numb themselves by “checking out” using technology and social media, drinking alcohol, and/or taking drugs. They may experience detachment or derealization, depersonalization, and challenges being present.

11. Negative Alterations in Thoughts and Mood.

Fear. During the exposure phase, the victim’s thought system is often dominated by a state of fear. Fragmentation of reality and self-perceptions, along with critical attachment injuries, immediately shift the brain to fear or survival mode. Victims’ thoughts usually focus on survival and protection from threats and harm, which then impact emotions and mood. Indeed, PTSD and trauma can be conceptualized as conditions of fear in which the brain and the psyche are in survival mode due to perceived threat. When the psyche switches to a fear-based survival mode, the organizing or dominant agenda involves scanning the environment for threats and being prepared to respond, defend, and protect. Notably, fear is the root emotion of anxiety; thus, anxiety disorders are common both during and after the collision of the PRE with the DCSR.

Grief. In addition, the sudden loss of self and PRE can be severe and experienced as extremely distressing and intense. When all previous perceptions of reality are suddenly called into question and negatively altered, these types of losses result in significant grief. As discussed above, the REF is often experienced as a “psychic death” and associated with a grieving process.

Anger and dysregulation. When someone comes to realize the deceptions, as well as the degree and nature of the violations, that existed during the covert phase, they often feel a deep sense of betrayal. As a result, they might experience significant emotional and behavioral dysregulation. They might also react intensely with anger and rage. People describe such emotions as “coming in waves” or “like being on an emotional roller coaster” and will often require help with managing and coping with such intense and potentially debilitating alterations in thought and mood patterns.

12. Trauma-related Arousal and Reactivity. During the exposure phase, victims’ brains are often in fear mode, and their systems are “on guard” (some victims have described their state of mind as “waiting for the next shoe or bomb to drop”). The specific fear responses and re-experiencing triggers that so many victims suffer through during the exposure phase all contribute to the risk of post-traumatic stress symptoms (including intense fear, panic, and horror). The brain literally goes into survival mode, where primary/regressed defenses dominate the psychological system, causing a hypervigilant state of survival, scanning for threats and preparing to respond. Specific types of emotional, psychological, and relational harm and abuse (e.g., victim-based aggression or episodic physical violence against others) may also occur during this phase.

13. Distress and Functional Impairment. Individuals who experience continued integrity abuse, along with REF, relational rupture, and attachment injury – usually all at the same time – often suffer from acute distress and functional impairment that can persist from months to years. This can include experiences of external crises and environmental destabilization, which refer to significant interruptions and crises within victims' everyday lives (e.g., significant changes in routines or living arrangements; alterations in family structure, co-parenting functions, allocation of resources/ financial burdens; physical and medical symptoms such as sexually transmitted infections). These dynamics are a significant source of stress that alone can cause functional impairment. Unfortunately, such destabilization can sometimes cause people to submerge deeper into their trauma symptoms and present even greater obstacles to working through the traumatic experiences. Physical, sexual, and psychological abuse not only often result in lifelong physical and mental health consequences for those involved, but they also can impact interpersonal, social, and economic functioning (American Psychological Association, 2010).

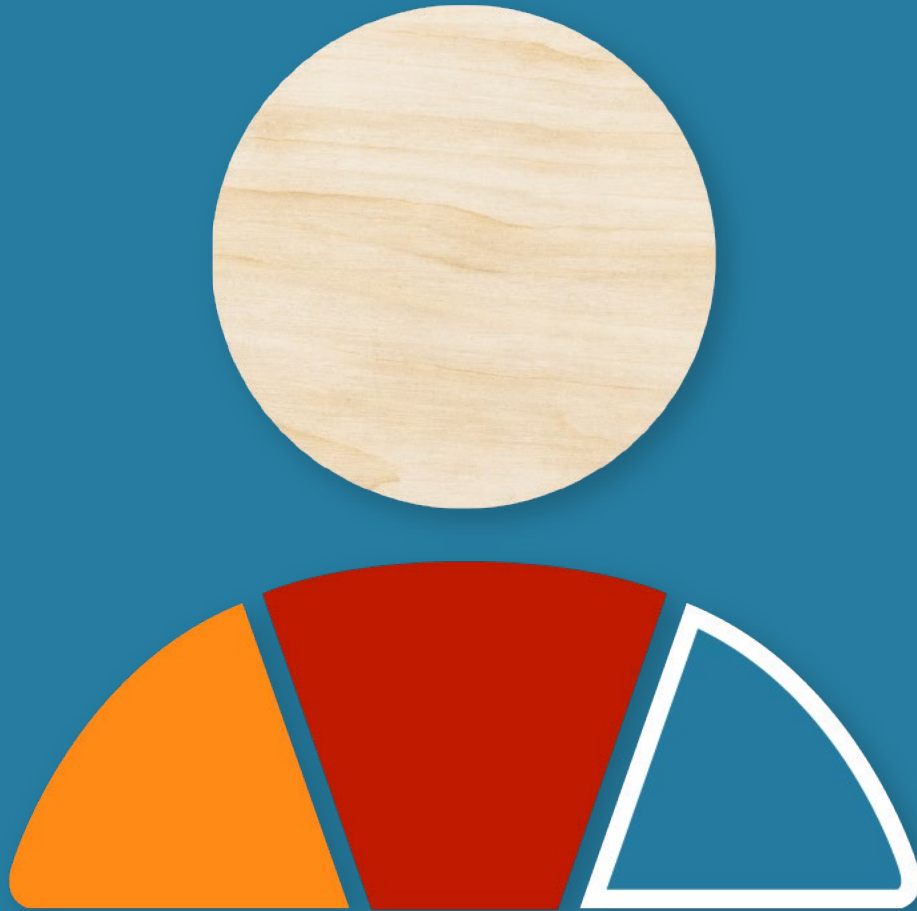
14. Dissociative Symptoms. Dissociation includes a wide array of experiences and exists on a continuum ranging from mild emotional detachment, or not being present, to a more severe disconnection from physical and emotional experiences. Dissociation can be regarded as a coping or defense mechanism that attempts to minimize, master, or tolerate traumatic stress. It involves an externalized state that detaches from the present environment in an effort to numb or escape from present ego states or emotional experiences. The major characteristic of all dissociative phenomena involves a detachment from reality and pain (not a loss of reality as in psychosis). More severe or symptomatic dissociation involves:

- alterations in consciousness (on a continuum)
- separate streams of consciousness, identity, and self
- dissociative amnesia or fugue states
- amnesia or hypermnesia
- transient dissociative episodes
- depersonalization (sense of the self as unreal or “just going through the motions”)
- de-realization (sense of the world or reality as unreal)
- reliving traumatic experiences (through PTSD symptoms or through ruminative preoccupation)
- impacts to concentration, being present, or attention

This type of coping mechanism often creates subsequent consequences and symptoms, which negatively impact identity reconstruction and perceptions of reality, self, others, and truth, all of which are vital to healing.

Symptom Progression Phase

*Life in the Aftermath of Learning About
the Secret Sexual Basement*



- The aftermath of the covert and exposure phases
- Includes short- and long-term post-traumatic symptoms
- Core injuries to reality, self, identity, sexuality, and gender
- Persistent negative relational patterns causing further harm

15. Symptom Progression Phase Integrity-abuse Shaping. Symptom progression phase integrity-abuse shaping refers to the integrity abuse that occurs during the symptom progression phase of DST, the short-term and long-term impacts and symptoms in the aftermath of the covert and exposure phases, as well as core wounds related to sexuality, gender, and the post-fragmentation reconstruction processes of ego, self, and reality. When abusers are caught and exposed, this does not necessarily mean that the integrity abuse stops. During the progression phase, we might see the following behaviors arise (some of which started in the covert or exposure phases):

- violations of agreements or commitments
- inability or unwillingness to be accountable
- refusal to participate in repair or healing
- inability to provide valuable care and support
- pathologizing victims' reactions
- demands that victim get over it and move on
- sexual entitlement and demands
- psychological manipulation and gaslighting
- lying/lying by omission
- callous attitudes towards victims
- assumptions and expectations of impunity
- continued engagement in the DCSR
- continued domination and control (covert and/or overt)

These continued abusive behaviors often cause both acute traumatic experiences and progressive, ongoing CTS in the form of symptoms such as:

- dissociation
- compartmentalization
- denial/normalization
- reality and ego confusion and instability
- chronic depressive disorders
- chronic anxiety disorders
- numbing and protective symptoms
- physical body and medical symptoms
- persistent negative relational patterns
- sexuality and gender symptoms
- learned helplessness
- learned compliance
- loss of faith in humanity

Victims in these situations are likely to experience ongoing symptoms related to second brain injury and enteric system confusion (i.e., an inability to be aware of and to effectively respond to one's "gut instincts"). These individuals may report an ongoing sense of confusion as well as being unsure of what to believe in or what is real. Sometimes, a DCSR emerges again in this phase - the abuser may return to their secret basement and re-engage in deception - thus, overlapping a new covert phase with the existing symptom progression phase. This compounds trauma and injuries, adding more complexity and severity to symptoms and additional harm to those involved.

16. Reality-ego Injuries and Reconstruction. Reality-ego injuries refer to symptoms and processes related to loss and grief as well as metabolizing and adjusting to REF and the reconstruction and reclamation of core functions and systems related to the post-fragmentation of identity, ego, reality, gender, sexuality, and human re-attachment and human re-connection. This may include continuing and sometimes persistent exposure phase symptoms related to post-traumatic stress due to the injury of the person's PRE and their sense of self. Both reality and self were injured in the exposure phase, and both will continue to experience symptoms for quite some time after discovery and/or disclosure. Reconstruction represents the emerging recognition of what a new reality and a new sense of self (or ego) may mean and the complexities involved in this type of development. During the progression phase, the fragments from the exposure phase should be metabolized in order to start the healing process of grieving, understanding, and making sense of a new reality. This process involves forming new, basic building blocks of cognitive assumptions of what is real or true; increasing feelings of self-worth; and improving second brain functioning. Individuals going through this process will also need to radically shift how they perceive their lives, including their universal sense of meaning. Sometimes faith in life or trust/attachment to God can rupture, causing a type of attachment injury that leads to psychic destabilization of the brain functioning.

As victims metabolize each fragment, they likely will re-experience a number of stress-related symptoms that impact their emotions, thought systems, and relationships, as well as their sense of self, the perceptions of their partners, and their understanding of reality. In addition, as victims digest this material, they may make new realizations and connections between the PRE and DCSR, thereby leading to even greater REF and more fragments to be metabolized. They may also continue to become informed of the types and the depths of deception, the tactics and schemes that were used, the ways things were covered up and hidden for so long, and more of the nuances and subtle aspects of the integrity abuse, which may be just as disturbing and difficult to digest. This creates a cycle in which re-experiencing trauma occurs in waves, as old and new fragments of the pre-existing realities are processed. During this phase, victims are likely to experience some of the following types of alterations:



Alterations in self-perception. During this phase, victims often experience unwelcome and distressing symptomatic versions of themselves while they mourn the loss of their pre-existing selves and hold out hope for a replacement version. Victims often sense that they are inhabiting a new, post-stressor self that they feel alienated from. This process can result in confusing and/or negative ego states or experiences of the self. Alterations in self-perception include feeling helpless, paralyzed, disempowered and/or overpowered, weak, shameful, guilty, self-blaming, defiled, stigmatized, different from others, socially anxious, unworthy, feeling unattractive or sexually unappealing, alone, and/or misunderstood.

Persistent integrity abuse can make it difficult for victims to locate their fragmented selves and may rob victims of the opportunity for optimal, healthy self-reconstruction. Victims in this type of situation may become further symptomatic, feel disempowered, and experience additional, fragmented sub-selves that fluctuate over time. There may be a sense of social stigma or contamination that impacts victims' self-perceptions, and a sense of victimization may become fused with self-reconstruction.

Alterations in partner-perception. During the symptom progression phase, victims may experience both a loss and a replacement of their partners. They have lost their pre-DCSR partners and must come to terms with new perceptions of their partners that may be quite different, unwelcome, and unsettling. Integrating perceptions of PRE partners with symptom progression phase partners is often an unwelcome, distressing, and aversive process. In many ways, the partner who emerges during the progression phase may seem like a frightening and threatening stranger, a person that may not be recognizable. Partners may use words such as "monster" or "imposter" to describe their abusers. On the other hand, victims may come to see their partners as malicious, deficient, immature, pathological, sick, and/or pathetic, or they may attribute power to the abuser.

Attributions like these may be distorted and misaligned with reality because they are generated through a filter of harm, pain, disbelief, and anger. Attributions made from this space often focus intensely (and sometimes exclusively) on the negative features of the person who caused the harm and pain. During the symptom progression phase, abusers may also be providing ongoing examples of these negative characteristics, resulting in additional confirmation to victims that their altered perceptions are accurate.

Alterations in reality-perception. DST victims experience a loss of their previous realities, a difficult grieving process, and an often unwelcome, distressing, and aversive integration process. During the symptom progression phase, victims will become progressively more aware of their new realities. They will need to take time to metabolize all of the new information, thoughts, and feelings and to reconstruct a new sense of reality with a sense of strength or stability. As the person metabolizes the fragments of the PRE, however, new information gets absorbed, resulting in continued symptoms of REF, often distressing episodic re-experiencing, and perceptions of the world as dark, negative, sick, toxic, dangerous, and deceptive. This can result in chronic depression, anxiety disorders, and/or physical symptoms.

17. Sexual Symptoms and Functioning. After the exposure shock and acute symptoms post-exposure to sexuality (Minwalla, 2006, 2011), there may be ongoing and emerging symptoms related to alterations in sexual functioning and core sexuality-related dynamics. The sexual symptoms and functioning of partners impacted by deceptive sexuality are often similar to those for women who have been raped or sexually traumatized (Minwalla, 2006). As noted in Minwalla (2006, 2011b), partners may experience:

Sexual aversion, sexual shut down, and sexual constriction as a form of surviving and attempting to protect against the perpetrator. There can be months or years of avoiding sexuality with one's partner.

Intrusive and disturbing thoughts and images that make sexuality, including attempting to be sexual, a challenge. Specific images of the DCSR, specific sexual positions or places, and specific ways that the partner may react all may trigger re-experiencing reactions that can interfere with sexuality. There may be symptoms that impact a person's sense of sexuality as "being dirty and feeling contaminated" due to DST.

Anxiety about the possibility of having contracted a sexually transmitted disease (STD) or sexually transmitted infection (STI). Such infections sometimes lead to the loss of pregnancies or induced abortions and other serious gynecological trauma and physical consequences. Some people find the medical experience of being tested for an STD or STI a humiliating or distressing scenario.

Hypersexual, compulsive, and/or medicating sexual behaviors.

Hypersexuality may often be a survival "fight response," which may occur in the exposure phase, but can continue or emerge in the progression phase. These hypersexual reactions can be primal attempts at sexual and gender confirmation, finding control in a context of traumatic lack of control, a survival reaction related to attachment, a way of reclaiming a sense of control, etc. Some may also engage in obligatory sexuality and psychological constructs and self-generated attempts to please and meet perceived sexual demands (e.g., increasing sexual frequency, expanding boundaries, etc.). Individuals who present with hypersexuality and/or obligatory sexuality often report feelings of regret, guilt, shame, disgust, and sexual fragmentation, which in turn lead to even more trauma-related symptoms (e.g., around sexual self-esteem; negative schemas and emotional shaping associated with systems of sexual and gender domination, control, etc.).



Body image issues. Victims may experience body image issues, including feeling self-conscious, feeling sexually unattractive, or feeling competitive with others to affirm one's sexual or gender esteem and identity. Sometimes a person may turn to plastic surgery, such as breast augmentation or vulvar tightening. There may sometimes then be regret and a feeling of shame or further wounding at having had this type of surgery under such circumstances.



Important Note: *Compulsive-entitled sexuality (CES) problems and disorders most commonly do not include sexual offending. However, sometimes CES does include sexual offending behaviors, which are sexual behaviors that lack consent, including marital rape. Some partners are raped as an ongoing system of sexual domination and violation. In response, dissociation and detachment during or around sexuality often become a vital coping strategy. In such cases, symptoms of rape trauma syndrome (RTS) likely emerge and will require careful, conscious clinical treatment.*

18. Gender Wounds and Symptoms. Gender identity/gender esteem is a primary core dynamic in self-construction, self-esteem, and self-worth. It is foundational to our overall psychological functioning and adjustment. In a clinical system of traumatic injuries, gender identity/gender esteem is delineated in order to more fully appreciate and understand the traumatic wounding in service of repair and integration of regenerated gender fragments and gender esteem, along with the reconstruction of gender identity in a post-DST clinical context.

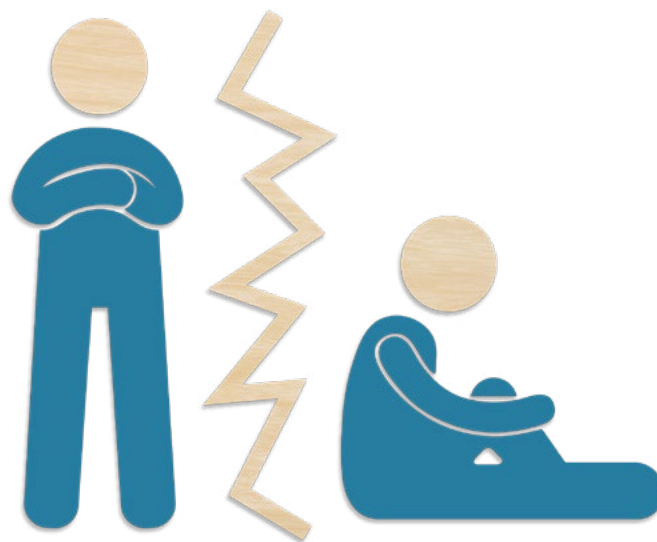
To the extent a person is subjected to gender pathology, they will likely incur gender-based wounds, some which may be unconscious or difficult to name and describe but experienced as a form of psychic pain and suffering. Partners exposed to deceptive sexuality and integrity-abuse behaviors are often profoundly impacted at the core of their gender identity/gender esteem (Jason & Minwalla, 2009), which often includes damage to ego structures and core gender constructs such as wife/husband, mother/father, female/male, sexual being, and worthy being. Issues and potential symptoms related to gender wounding include body image disturbances, eating disorders, and body dysmorphic reactions, to name just a few.

19. Persistent Negative Relational Patterns. Healthy and secure attachment to human beings is essential to psychological health (Bowlby, 1979). Disconnection from human beings results in pain, dysregulation, and disease. Rupture from what was experienced as a secure attachment, which included psychological and emotional dependency, can be experienced as a critical traumatic event and process (Johnson, 1996).

Upon discovery, the abuse victim often experiences the loss of their “safety net” or “go-to person.” The abusive partner also experiences the loss or rupture of a “safety net” or “go-to person,” creating trauma and destabilization for them as well. This sudden and severe attachment injury is experienced by everyone involved in the relationship, even if they caused the injury to occur.

Deceptive sexuality deeply impacts the abusive partner and the victim, as well as profoundly alters the relationship as a separate, third entity. The relationship – the “us” itself – is traumatized and may become very negative, unhealthy, and toxic. To understand this, the conceptual view here must be of the relationship not as two separate people, but rather as the energy which existed and emerged between two people, forming a third and separate injured entity. The energy of this entity experiences negative impacts and changes over time, which may slowly become a form of CTS that impacts all three entities. The relational synergy is harmed, and the relational system that existed between the two people has become another casualty of the abuse.

When we have two people whose lives and relationship are forever altered from their pre-existing form, each person’s pre-existing attachment wounds, from birth until the present, may be activated. This complicates the conflictual instincts in each person. Partners may feel conflicted about whether to depend on or to instead defend and protect against each other based on their primal and survival instincts. These instincts can be powerful and activated concurrently, fluctuate rapidly back and forth, or evolve and change progressively over time, further shaping the injured relationship.



Most often, the abusive partner may be experiencing a type of post-traumatic stress due to relational rupture and may have inadequate and insufficient tools or maturity to deal with the trauma upon exposure. In these cases, the abusive partner is unable to recognize their participation in any type of abuse problem and may continue the integrity abuse. They may be callous, defensive, and abusive towards the intimate partner and the relationship. Their inability to take ownership, fear of the consequences, and lack of comprehension about abuse injuries and traumatic repercussions combine with their pre-existing deficits and limited capacities for healthy emotional or relational responses. As a result, they may continue to perpetrate defensive and abusive reactions, which harm the partner and the relationship.

It is critical, however, to see both people in the relationship as full human beings and not objectify or dehumanize them, nor to distort reality to “protect the victim.” The victim remains a human being and should not be considered a “neutral object,” “non-relevant object,” or any other objectification of the victim’s humanity. Both people are adults who are responsible for their actions.

Victims who are experiencing post-traumatic reactivity, arousal, and stress symptoms caused by the subjugation to abuse may have reactions that are aggressive, violent, endangering, abusive, unhelpful, distorted, confusing, scary, and/or otherwise harmful to others and their relationships. They may experience rage, primal screams, loss of impulse control, extreme fear and hypervigilance, startle responses, high reactivity to triggers, and surges of fear and anxiety associated with re-experiencing. This post-traumatic arousal and reactivity is an expected symptom of abuse and trauma (see Exposure Phase on page 13).

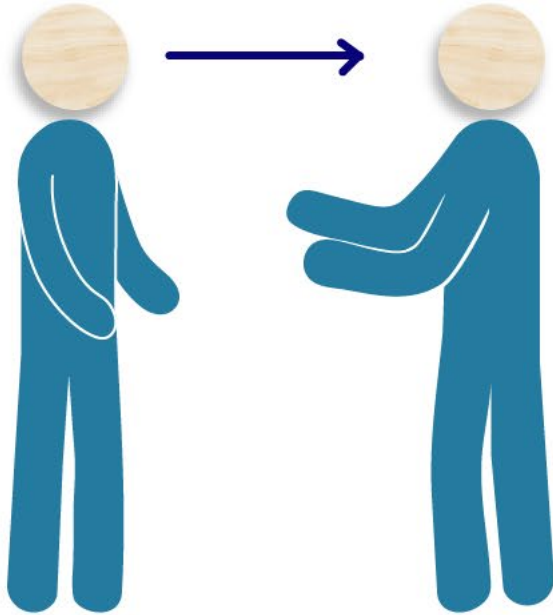
These common behaviors may be easily misunderstood and misapplied in ways to blame the victim. Therefore, it is critical to shine a light on one of the most common tactics used by abusive partners, which is to deflect or defend against responsibility for the abuse by **pathologizing the victim’s reactions and actions**. The symptoms the victim experiences post-trauma are a direct result of the abuse and trauma. It is unjust, unfair, an intentional manipulation and mischaracterization of the truth, and another insidious form of integrity abuse to take advantage of a victim’s post-traumatic reactivity and normal human reactions without acknowledging the cause and context of the reaction (see Symptom Progression Phase on page 22).

However, harm, abuse, and violent actions, even when stemming from abuse and trauma in the victim and as part of the natural and expected symptoms of trauma, is still harmful and will hurt others and relationships. The origin of the abuse does not diminish the harm of abuse on other human beings. Harm perpetrated by victims should be understood within the context of abuse and trauma – with integrity, empathy, and justice for the victimization always considered as important factors in maintaining perspective. This perspective should never be used to collude with the victim’s abuse, violence, or harm to other human beings, nor should being a victim of harm entitle a victim to violence, perpetration, or abuse. While it may be tempting to overlook harm perpetrated by the victim to stay clear of victim-blaming, it can become a dangerous form of patronizing as well as a dehumanizing and objectifying view of the victim. Victims are responsible for post-traumatic actions that hurt others, just as the abusive partner is fully responsible for their actions that hurt others.

The relational ruptures, attachment injuries, relational disconnection, and inability to reestablish healthy or even regulatory attachment may become an additional source of traumatic experience for both partners. Both partners, for many different reasons, create defenses and triggers to each other, which result in negative relational trauma-related patterns (post-exposure phase) where both people are being hurt, repeatedly, creating further detachment, human harm, and relational rupturing. These **persistent negative relational patterns** and their repercussions may absorb much of the energy and resources in the relationship, depleting and exhausting healing attempts. The lack of ability for reattachment may result in traumatic reactive escalation or erosion of attachment attempts and potentially lead to the eventual loss of relational stability and basic dependency.

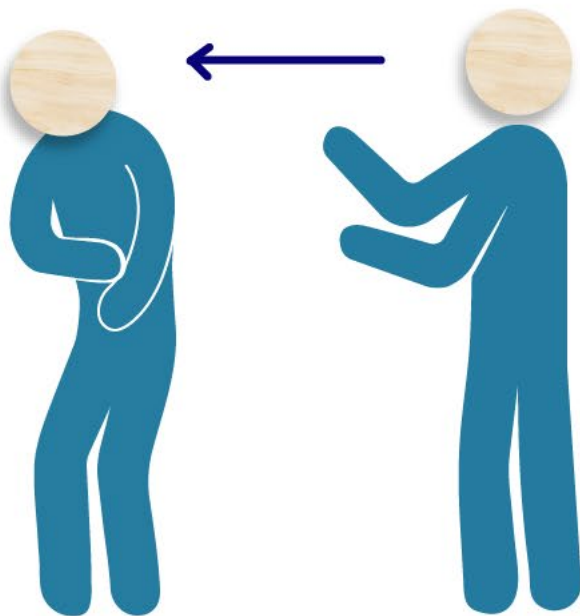
This is precisely why building a secret sexual basement is so damaging. The eventual outcome includes a traumatized and injured relational reality, lacking in secure attachment or even basic safety or health for both partners as well as for children and the family system. Despite sincere attempts at healing, both people in the relationship are in pain and may be so reactive to each other and so overwhelmed by the prospects ahead, that they are unable to sufficiently transform the negative energy between them, and so both partners may continue to engage in persistent negative relational patterns.

Conflictual Survival Instincts



Depend: Turn Towards for Protection

Survival instinct in an attachment relationship is to turn toward the “go to person” when needed for survival and in times of crisis



Defend: Guard Against for Protection

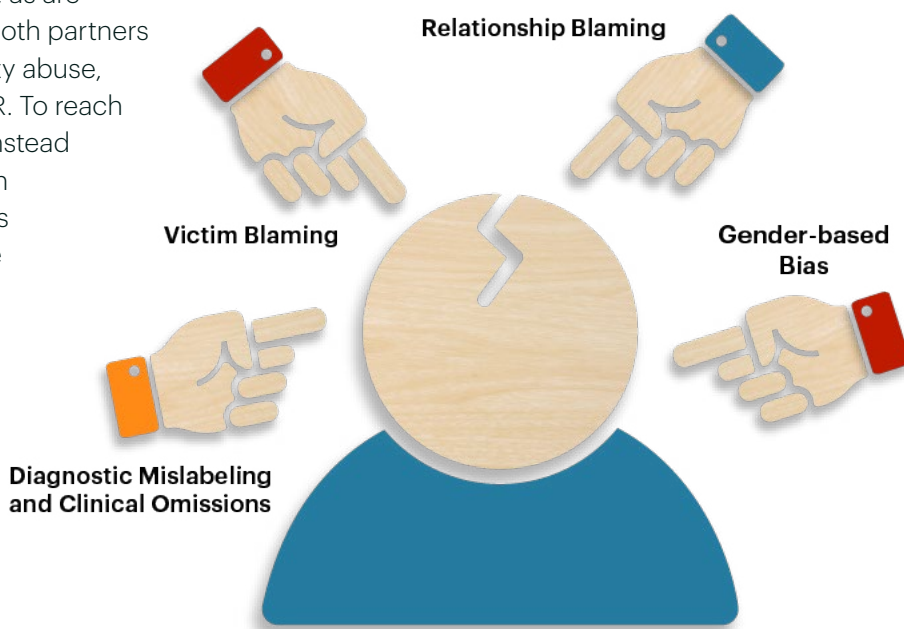
Survival instinct when threatened, abused, or harmed is to defend, protect, guard against, and stay away

20. Family, Communal, and Social Injuries. While trauma impacts a partner's interior world and primary adult attachment, it also has far reaching implications for other relationships, including the parent-child bond, the child(ren), the family system, the social world, the experiences of being in public, a sense of community that provides stabilization and dependency, and relationships to others in general. The consequences on social and interpersonal functioning can be a significant source of trauma and may involve multiple attachment injuries, significant grief and loss over many relationships, and profound, sudden, and prolonged alterations in relating to other human beings.

Often a family system is invariably impacted by deceptive sexuality. Partners may end up holding secrets from loved ones and family members. Partners may lose friends and/or may find out their friends colluded with the DCSR. The trauma may also cause social constriction and avoidance, leading to significant changes to how the partner relates to social reality, community, public space, and human beings in general (e.g., agoraphobic symptomology, loss of faith in humanity).

Partners having to bear witness to profound traumatic impacts on their children, in particular, can experience specific trauma as a result. The ongoing reality of children being impacted and harmed may provoke deep instinctive reactions and biologically-based protective parental instincts (e.g., mama bear, hornet's nest). Partners who see their children suffering or demonstrating symptoms due to the repercussions of deceptive sexuality often experience a significant source of traumatic re-experiencing, which induces, for example, episodes of rage.

21. Treatment-induced Trauma. The term *treatment-induced trauma* (Minwalla, 2012b) specifically describes clinical symptoms among partners and spouses impacted by sex addiction. Treatment-induced trauma involves both the induction of trauma and the traumatic symptom sequences experienced by the partner or spouse. Treatment-induced trauma is a clinical or medical intervention that causes harm to the patient or client. In treatment-induced trauma, traumatic consequences ensue from clinical interventions, or serious clinical omissions, perpetrated by therapists and medical professionals. Often this dimension of trauma is caused by clinical interventions that are fundamentally organized around the traditional co-sex addiction model (Carnes, 1991), the single-concept codependency model, or other traditional interventions that fail to recognize and treat DST among partners. For example, some "sex positive" counselors and educators may prescribe date nights or sex nights for traumatized and sexually abused partners and couples impacted by deceptive sexuality (Minwalla, 2012b). Further, traditional interventions that tell couples to "stay on your side of the street" is often harmful, as are "it takes two to tango" approaches that blame both partners and the relationship as the cause for the integrity abuse, the compulsive-entitled sexuality, and the DCSR. To reach out for help and to be let down, let go, or hurt instead of helped is one of the most serious violations in medicine, therapy, and attachment relationships (American Psychological Association, 2010). We believe that a more effective clinical strategy recognizes the clinically and ethically important utilization of an *abuse-victim-trauma consciousness* that informs the treatment approach.



"The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient's present symptoms and the traumatic experience is frequently lost." (Herman, 1997)

Integrity-abuse Shaping of the Intimate Partner: Behaviors, Patterns, and Ongoing Progressive Conditions (Summary Table)

Covert Phase Integrity Abuse

- | | | | |
|--|--|--|---|
| <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • Covert or overt blaming of 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) | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • Intentional withholding of relevant information (e.g., about the DCSR) in treatment (individual or couples) |
|--|--|--|---|

Exposure Phase Integrity Abuse

- | | | | |
|---|--|---|--|
| <ul style="list-style-type: none"> • Lying/lying by omission • Deception, 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 | <ul style="list-style-type: none"> • Rationalizing • Justifying • Projecting • Denying • Covering-up • Partial disclosures • Staggered disclosures • Revising facts and history • Obstructing • Stonewalling • Refusing to cooperate or speak • Technical manipulation • Verbal abuse or diminishment • Intimidation and threatening | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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

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|--|---|---|---|
| <ul style="list-style-type: none"> • Lying/lying by omission • Deception, 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 | <ul style="list-style-type: none"> • Violating agreements or commitments • Inability or unwillingness to be accountable • Refusing to participate in repair or healing • Inability to provide valuable care and support • Pathologizing the victim's reactions • Demanding that the victim get over it and move on (demonstrated impatience) • Sexual entitlement and demands (violations) | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Resisting, avoiding, prematurely terminating, or abandoning treatment |
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Clinical Considerations

This paper offers an introductory and descriptive overview, rather than a comprehensive articulation. The clinical management and treatment of this type of abuse and this type of trauma among survivors 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 purpose of this paper is to introduce a specific type of trauma-stress disorder experienced by victims of a specific type of psychological and relational abuse.

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

- Abuse 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, physical, and/or sexual coercion.
- Abuse usually produces fear and trauma in those being victimized.
- Deceptive sexuality includes associated 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 and compulsive sexual and/or sexually-entitled behavioral patterns (CES), all of which must be clinically addressed and treated.
- Treatment should be informed by a consciousness of an abuse dynamic, an abuser, and a victim(s), not just a sexuality problem.
- The impact of deceptive sexuality often results in deceptive sexuality trauma (DST), which is the trauma that results directly from the impact of IAD and CES.
- DST often impacts the domestic sphere, meaning the intimate partner, the couple, and sometimes children and the family system.
- DST can be conceptualized as an *Other Specified Type of Trauma-Stress Disorder* (DSM-5 code 309.89, ICD-10 code F43.8) that requires clinical treatment. DST often presents within the partner and relationship as a combination of both PTSD-related symptoms and CTS-related symptoms.
- The Deceptive Sexuality and Trauma Model proposes systemic and relational treatment approaches and case conceptualization when indicated. The person who has engaged in deceptive sexuality, the intimate partner, and the couple should be seen as three separate entities (like three plates spinning). Without careful clinical coordination between all three components (as opposed to compartmentalized approaches), 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).
- The Deceptive Sexuality and Trauma Model shines a light on the topic of gender and the role gender development plays in our psyches, in our society, and in our lives. This paper describes what remains largely an unnamed (at the time of this writing) type of gender-based violence, intimate partner abuse, and domestic/family abuse. Due to that fact that deceptive sexuality is often rooted in gender pathology, a gender-based consciousness should be integrated into clinical diagnosis and treatment considerations.

Glossary of Terms

Complex Post-traumatic Stress Disorder	C-PTSD
Complex Trauma Shaping	CTS
Compulsive-entitled Sexuality	CES
Deceptive, Compartmentalized, Sexual-relational Reality	DCSR
Deceptive Sexuality Trauma	DST
Integrity abuse	IA
Integrity-abuse Disorder	IAD
Pre-existing Reality-ego	PRE
Post-traumatic Stress Disorder	PTSD
Reality-ego Fragmentation	REF

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