The Tie that Binds: Sadomasochism in Female Addicted Trauma Survivors

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Women who develop addictive disorders to survive life trauma present a wide array of variant and perverse behaviors. This overview of sadomasochism examines the life trauma syndrome and the survival functions of addictions including self-injurious behavior, eating disorder, and sexual addiction. The etiology of sadomasochism is found in object relations damaged by neglect or abuse. Sadomasochistic dynamics function like brainwashing to oppress women in a subordinate position. Survivors turn childhood tragedy into triumph through sadomasochistic re-enactments of life trauma. An omnibus, developmentally-based psychotherapy for treating the ego states of female addicted trauma survivors included abstinence from addictive behaviors, abreaction of unresolved trauma, information reprogramming or reprocessing of trauma-related cognitive distortions, acquisition of nonaddictive affect regulation and self-management skills, prevention of relapse, and enhancement of capacity for intimacy, creativity, and spirituality. Case studies are presented to explore the types of sadomasochism and state-dependent treatment recommendations across five life domains.

Women who develop addictive disorders to survive life trauma present a wide array of variant and perverse behaviors. Their sexual perversions include compulsive masturbation, preoccupation with pornography, exhibitionism, and exploitative relationships (Gold, 1991; Schwartz, Galperin, & Masters, 1995; Schwartz & Southern, 2000; Stoller, 1975). The lifestyles of addicted trauma survivors manifest nonsexual variance such as self-injurious behavior, eating disorder, compulsive shopping, and codependency (Briere,
1992; Connors, Forward & Torres, 1986; Fullerton, Wonderlich, & Gosnell, 1995; Hernandez, 1995; Kaplan, 1991; D. Miller, 1996; Norwood, 1986; Schaef, 1987; Schwartz & Gay, 1993; Subby, 1987). Addicted trauma survivors typically present an identifiable sequence (i.e., “firing order”) of three or more addictions, which are revealed in a pattern of recurrent relapse (cf. Carnes & Delmonico, 1996; Griffin-Shelly, Sandler, & Lees, 1992; Whitfield, 1998; Wiederman & Pryor, 1996). The thread that connects the perversions or paraphilias and nonsexual variance is sadomasochism.

Women who experience life trauma in childhood or later stages of psychosexual development present a paradoxical dilemma. Their lives have become organized around avoiding or rejecting the truth of verbal, physical, and sexual abuse. Yet, their survival mechanisms, such as compulsive masturbation and self-cutting, re-create salient features of life trauma so it is impossible to forget. The life trauma syndrome includes at least eight domains of symptoms that capture the attention of survivors and caretakers: posttraumatic stress disorder, phobic anxiety, dissociative disorder, self-injurious behavior, addictive disorder, psychosomatic illness, depression, and compulsive disorder. As long as one is focused on the immediate suffering in one or more of the symptom domains, there is little opportunity to explore the underlying experience of trauma.

Over time, within and across the eight domains, symptoms become increasingly frequent, entrenched, or pathological. For example, older women who are trauma survivors present complex clinical profiles with years of anxiety and depression, several addictive disorders (especially chemical dependence, eating disorder, and sexual addiction) and psychosomatic illness, such as fibromyalgia and irritable bowel (Boyd, Henderson, Ross-Duwor, & Aspen, 1997; Briere, 1992; Brown, Stout, & Mueller, 1999; Clark, Lesnick, & Hegedus, 1997; Jarvis & Copeland, 1997; Leserman, Drossman, & Toomey, 1996; Mezzich, Tarter, Giancola, Lu, Kirisci, & Parks, 1997; Najavits, Weiss, & Shaw, 1997; Schwartz & Kohn, 1993; Stein & Barrett-Connor, 2000; Teets, 1995; Walker, Keegan, Gardner, Sullivan, Bernstein, & Katon, 1997; Whitfield, 1995, 1998). The accumulation of symptoms in the life trauma syndrome obscures the truth about pain and shame from the past. There are sadomasochistic dynamics within the trauma survivor that maintain the cover up at the expense of individual autonomy.

In addicted trauma survivors, there are four basic part-personalities or ego states organized around avoiding life trauma by replaying salient aspects of the original abuse experiences. Ego states represent covert, semi-autonomous states of consciousness or segments of personality that meet differentiated needs and functions in the trauma survivor (Watkins & Watkins, 1997). The ego states depicted in Figure 1 reflect combinations of two dimensions: self versus other and love versus hate.

The Sadist and Masochist parts are especially active in maintaining the life trauma syndrome and the resulting addictive lifestyle. This sadomasochi-
istic dynamic functions as a persecutory alter ego, which Putnam (1989) described as the “trauma membrane,” separating the vulnerable survivor from the reality of abuse.

When one is possessed by shame and rage, engaging in self-defeating and self-punitive behaviors (i.e., functioning in the Masochist ego state), the survivor will not remember abuse or, if it is recalled, there is a lack of congruent affect and integration. When one projects the pain and shame onto another, sadistically attacking, manipulating, or deprecating the targeted person (i.e., acting from the Sadist ego state), then the survivor avoids vulnerability and loses the opportunity to make meaning from personal suffering.

The Addict and Codependent parts of the addicted trauma survivors self system collude in avoiding resolution of life conflicts by getting stuck in power and identity struggles. The Addict is possessed by entitlement and dishonest role playing, while the Codependent evidences devaluation and objectification of the self. The Addict demands attention and dominates others. The Codependent loses oneself by submitting to others and guarding the secrets of trauma and addiction.
Sadomasochistic dynamics are rampant in the interior world of the trauma survivor. They are enacted through role playing in the addictive lifestyle. Self-injurious behavior, eating disorder, and sexual addiction are adopted to punish and suppress oneself or take revenge on others. Some clinical cases may be helpful to understand the sadomasochistic functions in addiction.

CLINICAL CASE STUDIES

Nadine E. is a 45-year-old white divorced female administrator. She has an extensive history of psychiatric hospitalizations in which she was subjected to restraint, antipsychotic medication, and electro-convulsive therapy to control her self-injurious behavior and para-suicidal gestures. She was diagnosed with depression and alcoholism. In her 20s, she developed binge eating disorder and sexual addiction. Her sexual addiction included compulsive masturbation, repetitive extramarital affairs, and sadomasochism. The sadomasochism was expressed in preferences for being spanked and punched, verbally taunted for being fat, and humiliated, in which she would masturbate in the nude in front of her open living room window (i.e., display humiliation). Nadine was sexually abused as a child by her stepfather and older brother, both of whom criticized her for being overweight. She also was molested by a physical education teacher. During a four-year marriage to a law enforcement officer, she was a victim of verbal and physical abuse. She has always felt responsible for caretaking her chronically physically ill mother.

Chloe S. is a 35-year-old white married female, who is trapped in a devitalized marriage of 10 years. She and her husband have not had sexual relations in three years. She engages in compulsive masturbation, typically while she is engaged in cybersex in which she plays the role of a dominatrix. Chloe was groomed to be the sexual partner of her father, who took provocative photographs of her from childhood through adolescence. He introduced her to various sex acts and provided intercourse for her 16th birthday present. Since childhood, she engaged in self-cutting and bulimia, purging through vomiting. Chloe was diagnosed with depression and obsessive compulsive disorder, due to her cleaning and organizing rituals.

Sandra W. is a 40-year-old black single female health professional. She has enjoyed tremendous financial and career success. Recently, her compulsive sexual behavior placed her professional lifestyle in jeopardy. She over-compensated from childhood for life trauma associated with poverty, death of her mother, and sexual abuse by uncles and older male cousins. She turned to high school studies and later compulsive working to cope with underlying anxiety and lack of trust. Sandra is troubled by perfectionism and a drive to maintain high status. Since adolescence she has experienced migraine headaches and gastrointestinal distress. She never let herself get seri-
ous in any dating relationships. Her life has centered increasingly on finding
anonymous male partners who use her sexually, sometimes in public places.
She became involved in swinging with a man she dates, having multiple
sexual partners and developing genital herpes. She has been using the com-
puter in the health clinic where she works to make sexual connections via
the Internet. Sandra was confronted by the clinic administrator for her Internet
and telephone activities.

Each of these women struggled to make sense of their lives, which were
haunted by sexual addiction and several other sadomasochistic manifesta-
tions of the life trauma syndrome. The case of Nadine reflected a very close
connection between the tragedy of childhood trauma and the “solution”
represented by masochistic sexual preferences. This type of re-enactment
may be considered isomorphic, very nearly maintaining a one-to-one corre-
spondence between past abuse and present addiction. In the case of Chloe,
her sexual addiction (and the other addictive disorders) represented her best
efforts to master her trauma through repetition compulsion or trauma replay
(Anzieu, 1986; Chu, 1991; Kuhn, 1997; Schwartz, 1996; van der Kolk, 1989,
2000). Her re-enactment is compensatory, making up for something that is
lost or missing and elevating her subordinate status by taking revenge (“get-
ing even”) with men. The case of Sandra portrayed the most complex, hid-
den variant of sexual addiction. She did not have any problems (until re-
cently) to the casual observer. She was held in high esteem in a very
responsible health profession. Her sexual addiction functioned as an escape
from the tyranny of her perfectionistic self-system (Baumeister, 1985,1991).
This form of sadomasochistic enactment may be considered escapist.

Having examined isomorphic, compensatory, and escapist cases of sexu-
ally addicted trauma survivors who followed the mandate of re-enactment of
life trauma, it may be helpful to examine closely the characteristics of sad-
omasochism. Then, one can address some particular needs in treatment

ORIGIN AND EXPRESSION OF SADOMASOCHISM

Sadomasochism is born in disruptions of object relations (cf. Berliner, 1958;
DeYoung & Lowry, 1992, Homer, 1979; Horney, 1967; Kernberg, 1984;
Kernberg, Seizer, Koenigsberg, Carr, & Appelbaum, 1989; Klein, 1948; Krueger,
1989; Mahler, 1968, 1975; Scharff & Scharff, 1994; Shengold, 1989; Winnicott,
1965). The initial stage of object relations emphasizes loving feelings in-
vested in bonding or attachment, symbiosis (i.e., the bliss of oneness as in
“Mommy and I are one”) and attunement or mirroring (e.g., rudimentary
empathy as in “I see me reflected in your eyes”). The second stage of object
relations involves transmuting anger and aggressive tendencies into ventur-
ing forth, differentiation, or individuation. Object relations normally culmi-
nate in resiliency, self-object constancy, and capacity for intimacy. Success-
ful object relations predict ability to delay gratification, tolerate frustration, and maintain a stable sense of identity.

When fledgling individuals are exposed to overwhelming stress or catastrophic loss, arising most commonly from abuse experiences, the differentiation process is thwarted. Some persons become stuck or fixated at particular points in the developmental process, while others acquire a vulnerability to regress to certain personality styles when exposed to novelty, ambiguity, or frustration.

Sadomasochism arises from dysfunctional blending of love and hate in psychosexual development (Horney, 1967; Reik, 1957; Ross, 1997; Stoller, 1975). Persons who are predisposed by faulty object relations to certain personality styles (i.e., compulsive, histrionic, narcissistic, or borderline) will be inclined to acquire approach-avoidance conflicts and sadomasochistic means for relating to the world. Individuals who experience personality disorder or character defect may objectify, manipulate, or exploit others. They use sexual behaviors to manage stress, reduce depression, vent anger, or bolster a fragile ego. Sadomasochism frequently is manifested as exaggerated role-taking. The BDSM (bondage and discipline, sadomasochism) games of adults engaged substantially in the lifestyle have the quality of structured play by children (cf. Blatner & Blatner, 1988; Winnicott, 1971).

Sadomasochism includes a continuum of sexual and aggressive behavior (Baumeister, 1985; Chancer, 1992; Moser, Lee, & Christensen, 1993; Moser & Levitt, 1987; Scarry, 1985; Schad-Somers, 1982; Spangler, 1977; Weinberg, 1987). Some sadomasochism (e.g., consenting adults who enjoy aspects in their intimate lives) is not pathological. BDSM devotees have asked professional organizations such as the American Association of Sex Educators, Counselors, and Therapists to recognize their lifestyle as an alternative sexual preference. The most common form of sadomasochism, present on occasion in most intimate relationships, is biting. Similarly, scratching is associated with passion in intense sexual relations. Subtypes of sadomasochism include bondage and discipline, display humiliation, status degradation, pain exchange, and piercing or scarification.

Whatever the type of sadomasochism, the functions of pain or shame are similar. Functions of sadomasochism are listed in Table 1.

<table>
<thead>
<tr>
<th>Table 1. Functions of Sadomasochism</th>
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<tbody>
<tr>
<td>Modulating arousal</td>
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<tr>
<td>Disinhibition of impulses</td>
</tr>
<tr>
<td>Merger with partner</td>
</tr>
<tr>
<td>Regression to childlike or dependent state</td>
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<tr>
<td>Exploration of power and control issues</td>
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<tr>
<td>Overcoming burden of selfishness</td>
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</table>
Sadomasochism in Female Survivors

Similar to self-injurious behavior and eating disorder, sadomasochism functions to modulate arousal (D. Miller, 1996; Scarry, 1985; Schwartz & Gay, 1993). Pain and humiliation reduce the threshold for physical sensation and raise the limit for emotional arousal. In this manner, sexual and aggressive impulses that are normally suppressed or repressed can be released within the narrow confines of a sadomasochistic exchange. Pain and humiliation also function to catalyze the experience of symbiosis, merger, or dependence upon one’s partner. After returning to a childlike dependence, it is possible to explore unresolved conflicts and traumas, although the scenes are camouflaged in the sexual variance.

There’s something comfortable about being tied up. Like when you were a baby and your mother strapped you in the car seat. She wanted you to be safe. It was an act of love... Only the one who hurts you can comfort you. Only the one who inflicts the pain can take it away (Madonna, 1992, p. 21, 26).

Having addressed love and bonding, the function of sadomasochism shifts to the exploration of power and control. Finally, sadomasochism serves the purpose of overcoming the burdensome aspects of selfhood in society.

Moser and Levitt (1987) observed that most males involved in sadomasochism adopted submissive or “bottom” roles to counteract the demands of being successful in society. Typically, these males held positions of high status and responsibility. They intentionally engaged in the stereotypical roles of submission and service in order to experience relaxation and comfort. Some overachieving women engage in sadomasochism to escape themselves. However, more women than men in the SM community re-enact their abuse history or engage in sexual acts to punish themselves (Moser & Levitt, 1987).

WOMEN AND SADOMATICISM

Both biology and society contribute to sadomasochism in women. Freud (1905/1962) viewed sadomasochism as basic elements of the sexual instinct: the sadistic/active role as masculine in origin and the masochistic/passive position as feminine in nature. In “feminine masochism” Freud (1905/1962) adopted a gendered theme in which masochism itself was dependent on masculinity, emerging as a form of inverted sadism. Reik (1957) expanded upon the idea of masochism as anger turned inward, identifying the origins of masochism in the control exercised by granting or withholding feces. By 1924, Freud hypothesized that masochism represented an expression of the death instinct. He expanded the concept beyond sexuality to include “moral masochism,” which reflected excessive superego (Strachey, 1964).

Deutsch (1944) emphasized the centrality of masochism in the psychology of women. She observed that masochism represented a biologi-
cal mechanism of human adaptation of the female to the painful experiences of menstruation and childbirth. The object relations theorists (Horney, 1967; Klein, 1948; Mahler, 1975) viewed sadomasochism as a means by which women handle normal aggression in the course of development. Sadomasochism emerges to cope with the demands of venturing forth or individuation. The developing girl leaves the comfort of symbiosis with one’s mother, and then experiences inner emptiness and profound mourning. The masochistic defenses, including perfectionism, self-mutilation, and para-suicidal behavior connect the fledgling person to mother. In the absence of external supports or the presence of overwhelming trauma, the child may become fixated at this primitive level of defenses (Kernberg, 1984; Kernberg et al., 1989).

Chancer (1992) indicated that patriarchal, male-dominated society fueled the sadomasochistic dynamic, prescribing dominant roles for men and submissive roles for women. The woman in patriarchal society is relegated to an inferior position.

...everything invites her to abandon herself in daydreams to men’s arms in order to be transported into a heaven of play. She learns that to be happy she must be loved as women in the Sleeping Beauty, Cinderella, Snow-White, she who receives and submits (de Beauvoir, 1974, pp. 23–24).

Submission and annihilation of the ego are required in patriarchal women (Wehr, 1987). Women internalize the oppression of the patriarchy, in which men are entitled to subjugate and dehumanize women, by developing the “psychic embed” of self-hatred (Daly, 1978).

Kaplan (1991) captured the essence of sadomasochism by reflecting on the origins of compulsive shopping, “the prototype of female perversion.”

In most of the female perversions, we can readily identify a collaboration between a woman’s personal solution to the traumas of childhood and a social gender stereotype of femininity...Kleptomania and its more socialized but equally perverse variant, compulsive shopping, have their personal roots in all variety of infantile humiliation and soul murders. But as in all perversions, these infantile traumas find correspondence in the social order (Kaplan, 1991, p. 513).

Whatever form a woman’s sadomasochism may take, it reflects an interaction of personal experience and gender role prescription by patriarchal society. Women who are addicted trauma survivors forge a combination of biological mandate, developmental challenge, personal traumatization, and sex role socialization into their unique sadomasochistic symptom complex. The sadomasochistic dynamics of the female addict or survivor represent an insidious brainwashing process by which the victim of trauma makes meaning of neglect or abuse.
SADOMASOCHISM AND BRAINWASHING

Women who re-enact abuse, directly or symbolically, use sex to complete a "brainwashing" process initiated by their perpetrators. The brainwashing characteristics of sadomasochism convert the trauma of the past to the sexual addiction of the present. Schein (1961) described the characteristics of brainwashing in his classic book, *Coercive Persuasion*.

Brainwashing, or coercive persuasion, has been used in war and espionage to oppress or subjugate groups of people, extract confessions and "right" behavior from individuals, and construct new identities (Schein, 1961). In the process of coercive persuasion, fundamental cognitions are "unfrozen," subjected to change or re-education, and "refrozen" in a new cognitive schema or identity. This brainwashing happens not only during warfare or spying, but also during childhood neglect, abuse, and traumatization. Trauma survivors subject themselves to ongoing brainwashing by means of the life trauma syndrome, especially the sadomasochism of eating disorder, self-injurious behavior, and sexual addiction.

In the original traumatization process, unfreezing constituted exposure to an overwhelming stressor or premature excitation of a vulnerable nervous system (cf. Chu, 1991; Kuhn, 1997; van der Kolk, 1989, 1994, 2000). The perpetrator of abuse was someone in a position of authority or trust, who is ordinarily charged with the responsibility of taking care of the child or dependent person. The context of the abuse produced change in the cognitive structure (e.g., in fixation or regression) and the content. Distorted cognitions that maintain particular schemas in the life trauma syndrome arise in the toxic educational process of abuse.

For example, Johnny, a middle aged wife abuser, learned from watching his dad beat his mom that it is acceptable to use violence "to keep her in line." Susie, his wife, acquired in her violent home the mistaken belief that physical abuse means love. Their dysfunctional relationship maintains the life trauma syndrome.

The refreezing frame or stage occurs when they re-enact their childhood experiences, strengthening distorted core beliefs and avoiding situations in which healthy or corrective emotional experiences might be introduced. They remain stuck in the repetitive pattern of abuse until futile attempts to stop and accumulating consequences produce the powerlessness and unmanageability of "bottoming out."

Characteristics of the unfreezing process described by Schein (1961) are listed in Table 2. Most of the characteristics of unfreezing are present in the abusive, addictive, and dysfunctional relationships that produce life trauma. Frequently, perpetrators are loved ones or trusted caretakers who re-enact their own trauma experiences through the neglect or abuse of a vulnerable person. Some perpetrators (e.g., in alleged cult abuse) are predatory in their intentional exploitation of the brainwashing process. In the unfreezing experience, the victim must depend on the perpetrator for support or meaning-making.
TABLE 2. Characteristics of Unfreezing

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<tr>
<th>Lack of typical social roles</th>
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<tr>
<td>Isolation from others</td>
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<td>Imprisonment or detainment</td>
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<tr>
<td>Novelty or strangeness of setting</td>
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<tr>
<td>Lack of sleep, nutrition, or exercise</td>
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<tr>
<td>Physical pain or discomfort</td>
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<tr>
<td>Humiliation or degradation</td>
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<tr>
<td>Cultivation of dependency</td>
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<tr>
<td>Repeated interrogations and false allegations</td>
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<tr>
<td>Threats of injury or death</td>
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<tr>
<td>Holding person responsible for the fate of others</td>
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<td>Disbelief or suspiciousness from others</td>
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<tr>
<td>Blaming and rejection by others</td>
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<tr>
<td>Exposure to propaganda</td>
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<tr>
<td>Promise of relief or release if cooperative</td>
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During the changing phase of trauma brainwashing (see Table 3), the survivor modifies core beliefs regarding oneself, others, and the world in order to reduce cognitive dissonance (Schein, 1961). In the example, Susie reconciles the incongruity that her beloved husband is beating her by concluding that she deserved the abuse or that his anger proves how much he loves her.

Characteristics of changing are applicable to original traumatization as well as sadomasochistic re-enactments. Changing moves the vulnerable victim from identity crisis to adoption of a trauma-bound new role (Carnes, 1997).

In the case study of Sandra, a successful professional who overcompensated for childhood trauma through compulsive working, she found the "solution" to her restrictive lifestyle in sadomasochism. She temporarily overcame the burden of excessive responsibility by adopting passive, masochistic roles in SM games. This masochistic ego state had its own name (Sandy), mannerisms, and preferences, which were at odds with the rest of her life (Leonard, 1989; Watkins & Watkins, 1997). As the sexually addictive role or ego state increased, Sandra experienced consequences of violating her stan-
TABLE 3. Characteristics of Changing

- Exacerbation of identity crisis
- Motivation to overcome identity diffusion
- Induction of new beliefs
- Identification with oppressor
- Acceptance of new identity
- Implementation of new role

dards and values, especially her fundamentalist religious beliefs. The accumulating dissonance contributed to the bottoming out that brought Sandra to treatment.

Characteristics of refreezing are associated with maintenance of life trauma as manifested in addiction. The refreezing phase (see Table 4) involves keeping the secret while maintaining the cycle of abuse. While in the changing phase, emphasis was placed upon the persecutor or perpetrator. Next, the “re-education group,” which could be the family in the case of incest trauma, minimizes or normalizes the abuse and provides outright rewards and secondary gains to the victim for assuming the role.

Coercive persuasion, or brainwashing, may occur unconsciously, naturally or intentionally in dysfunctional families, work places, and larger social systems that transmit distorted beliefs from one generation to the next. The distorted beliefs maintain a dynamic tension between forgetting or minimizing abuse and re-enacting the abuse in life trauma syndrome symptoms, primarily addictions. The sequence of unfreezing, changing, and refreezing accounts for the entrenchment of life trauma and addiction. Sadomasochistic re-enactments follow the brainwashing sequence as well.

In sadomasochism, there is a focus on concrete aspects of the immediate environment (Baumeister, 1985, 1991; Scarry, 1985). Painful stimuli focus the survivor on the here-and-now and away from emotional pressures, wor-

TABLE 4. Characteristics of Refreezing

- Confirmation of predictions made during captivity
- Reward for “right” action
- Acceptance and support from group
- Discussion in re-education group
- Re-establishment of comfort and status
ries, and higher-order thought processes. As arousal increases, the habitual cognitions are unfrozen and the person shifts into childlike, dependent ego-states. In the vulnerable state, the sadomasochist loses oneself in the experience and bonds with a real or imagined partner. The person is highly suggestible and takes on the role that is scripted or that the situation demands. There is relief and release with powerful rewards, including orgasm. In this manner, the person touches on unresolved conflicts and traumas, but acts out sexually to preserve the illusion of power, control, or mastery.

Psychotherapy affords an alternative to addictive re-enactment that actually gets to the heart of unresolved trauma. Therapy for female sexually addicted trauma survivors is similar to the practice of sadomasochism and generally follows the sequence of coercive persuasion.

PSYCHOTHERAPY FOR SADOMASOCHISM

Psychotherapy for addicted trauma survivors actually resolves the paradox of the life trauma syndrome by abstaining from addiction and other re-enactments and reliving the original trauma. Three components of therapy correspond to the phases of the coercive persuasion process (see Table 5).

Instigation involves catalyzing or reviving the unresolved trauma to overcome the constraint or overcontrol of the life trauma syndrome. Reprogramming methods attempt to confront and modify distorted core beliefs. Containment neutralizes the tendency toward re-traumatization by helping the survivor with grounding and meaning-making. Instigation corresponds to the process of therapy, while containment fits the structure of therapy. Reprogramming addresses the actual content of therapeutic interventions.

Psychotherapy for sexually addicted trauma survivors embraces concurrent treatment of trauma and addiction. Although there is controversy surrounding the appropriate timing for trauma work among recovering women (Dayton, 2000; Evans & Sullivan, 1995; Kaufman, 1994; Whitfield, 1995, 1998), recurrent relapses among survivors demand therapeutic attention. An omnibus, developmentally-based psychotherapy for this population includes abstinence from addictive and compulsive behaviors, abreaction of unresolved trauma, information reprogramming or reprocessing of trauma-related cognitive distortions, acquisition of nonaddictive affect regulation and self-man-

<table>
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<th>TABLE 5. Stages in Brainwashing and Psychotherapy Process</th>
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<tr>
<td>Brainwashing</td>
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<tr>
<td>Unfreezing</td>
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<td>Changing</td>
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<td>Refreezing</td>
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agement skills, prevention of relapse, and enhancement of capacity for intimacy (Schwartz & Southern, 1999).

The particular methods within the omnibus treatment model unfreeze, change, and refreeze trauma-maintaining sadomasochistic schemas. These cognitive-behavioral templates are intrinsically self-limiting because they filter out corrective feedback and nutritious life experiences. Instigation methods unfreeze the schemas associated with trauma-avoidance, self-sabotage, and addictive re-enactment. Reprogramming interventions target specific thoughts and actions linked to sadomasochism. Containment facilitates accommodation of new meanings into an increasingly resilient, cohesive sense of self, in effect, repairing damaged object relations. Therapy affords opportunities for new perspectives and behaviors, satisfying developmentally-based needs for safety, trust, hope, power, and love.

Instigation catalyzes the reliving of unresolved trauma, which may be "encapsulated" or hidden from ordinary waking consciousness. Instigative methods are exposure-based, aimed at increasing anxiety or distress beyond the levels typically tolerated by the survivor. In order to learn new, nonaddictive means for coping with distress, the therapist and patient must contract to prevent responses that lead back to the defenses of the life trauma syndrome. Instigative methods include passive approaches such as environmental restriction and response prevention (Suedfeld, 1980). Imaginal techniques, such as hypnotherapy and Eye Movement Desensitization and Reprocessing (EMDR) (Hammond, 1990; Parnell, 1999; Shapiro, 1989; Yapko, 1990), represent midrange instigative approaches. The most active, direct approaches to instigation are flooding, implosive therapy, and abreaction (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999; Stampfl & Levis, 1967).

The reprogramming methods incorporate traditional cognitive-behavioral interventions (Dimeff & Marlatt, 1998; Freeman & Leaf, 1989; Marlatt & Gordon, 1985), dialectical behavior therapy (Linehan, 1993), and recent constructivist and narrative approaches (Freedman & Combs, 1996; White & Epston, 1990). In order to reprogram female sexually addicted survivors of life trauma, it is essential to introduce feminist therapy, which counteracts the recurrent brainwashing associated with patriarchy (Chancer, 1992; Daly, 1978; Hartman & Burgess, 1993; D. Miller, 1990; Schaef 1987; Wehr, 1987). The key to successful reprogramming of distorted schemas and core beliefs is the dismantling of old, self-punitive views and insertion or suggestion of intimacy enhancing constructs. The reprogramming methods include disputation, personal experiment, information reprocessing, re-attribution, and arousal reconditioning.

Containment refreezes new schemas and contents into integrated units of meaning from which self-soothing, self-agency, and self-cohesion evolve. Containment methods emphasize journal writing, dialoguing, narrative reconstruction, and bodywork. In containment, the "good-enough mother" of healthy object relations provides for safety, comfort, and empathy. Later, an
“inner father” facilitates self-control, encouragement/direction, and assertion. Containment fills the void originating from childhood trauma.

Instigation, reprogramming, and containment catalyze and repair damaged object relations. Psychotherapy introduces developmentally relevant themes: safety, trust, hope, power, and love. Each of the themes can be addressed within the four ego states of the addicted trauma survivor: Dependent, Addict, Masochist, and Sadist.

Within the safety theme, the Dependent ego state lacks the good-enough mothering to provide for the vulnerable aspects of self. Therefore, an appropriate intervention would be the systematic use of a transitional object. Deco-rating a dreamwork folder and selecting a safe object (e.g., a smooth stone or a stuffed animal) are examples of interventions that reconstruct the Dependent state. In this manner, core fears of rejection, abandonment, or annihilation are neutralized so the fledgling person can venture forth.

The safety theme also is important to the Addict ego state. Here the provision of structure and order is keynote. The Addict part-personality finds safety in a relationship with a sponsor, who functions like a mentor or surrogate parent. Sexually addicted women in recovery find invaluable the bond with a strong, wise, supportive sponsor.

The Masochist ego state can be possessed by the helpless, terrified infant. When these feelings emerge in daily life, they may be expressed in flashbacks or anxiety attacks. It is essential to develop “self help” for the victim and other vulnerable parts of self. The “safe place” technique uses as many sensory modalities as possible in order to construct a haven or respite from the intentional instigation of therapy. Addicted trauma survivors may require safe places at home or work and need a readily accessible scene in one’s mind. Nature scenes with concrete, immediately available containment are superior to the addictive re-enactment of pain or bondage that might otherwise occur.

The theme of safety is relevant even for the Sadist part-personality. The Sadist ego state incorporates numerous characters including terrorist, inquisitor, persecutor, saboteur, and critic. The collective function of the Sadist is to quiet or gag the Masochist (i.e., Victim) in order to separate the survivor from trauma experience. For each of the five themes, there are interventions for transmuting the shame and rage into productive anger. In the matter of safety, one must negotiate a treatment plan or contract with the Sadist to relieve that part of the sentinel role.

Table 6 illustrates the psychotherapy interventions for each of the five themes across the four ego states. While it is beyond the scope of the present overview to describe the application of each intervention listed in Table 6, there are several that are illustrative of the omnibus treatment model. Group is an essential tool for working through of trauma in addicted survivors. There is no adequate substitute for the powerful experience of group cohesiveness.
The Dependent ego state finds hope in self-help and psychotherapy groups. The group functions like a single survivor's mind. Cohesiveness among group members anticipates the integration or fusion that takes place near the end of trauma reconstruction.

Boundary maintenance helps the Addict ego state delay gratification, tolerate frustration, and identify healthy choices. Boundaries that define one's sense of self are inclusive and exclusive. Recovering addicts must exclude old triggers for relapse, while including pleasant and meaningful life experiences. By negotiating with oneself and one's sponsor healthy limits, the Addict gains capacity for venturing forth or individuation.

The Masochist learns about trust from graduated self-disclosure to safe people. Typically, the survivor struggles with recording in one's journal an abuse recollection. However, the act of writing alone may desensitize some of the trauma (Pennebaker, 1997; Smyth & Lepore, 2002).

Next, the survivor must decide how much to trust the therapist. The tool of the life history or autobiography can be used to provide the context for disclosure. The survivor shares some sensitive part of the life history and experiences in the disclosure a human moment (Hallowell, 2001). In this manner the survivor moves from her hiding place through the relationship with a trusted therapist to the community of group psychotherapy. A few survivors have shared their experiences in writing, music, film or other modalities (Aberbach, 1989; Leonard, 1989; Madonna, 1992).

The final theme is love. Yet, love was there from the beginning, the original source of attachment. Even the Sadist ego state is impacted by love. One intervention facilitates “getting even,” not by taking revenge, but by making restitution. In 12-Step recovery, Steps 8 and 9 address the significance of making amends. Direct and symbolic forms of restitution pay an existential debt and open new avenues for self-acceptance.

There are instigation, reprogramming, and containment techniques for each of the four ego states (Dependent, Addict, Masochist Sadist) across the

<table>
<thead>
<tr>
<th>Theme</th>
<th>Dependent</th>
<th>Ego State</th>
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<tbody>
<tr>
<td>Safety</td>
<td>Transitional</td>
<td>Sponsor</td>
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<td></td>
<td>object</td>
<td>Safe place</td>
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<td>Trust</td>
<td>Core conditions</td>
<td>Sensate</td>
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<td></td>
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<td>Hope</td>
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<td>Spirituality</td>
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<td>cohesiveness</td>
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<td>Love</td>
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<td>Exoneration</td>
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* Core conditions include accurate empathy, unconditional positive regard, and congruence.
five themes or life domains (Safety, Trust, Hope, Power, and Love). By offering instigative interventions, when the survivor is stuck in the overcontrol or constraint phase of life trauma, the therapist catalyzes a natural developmental process by which lost experience is relived. When the ego states are unfrozen, core beliefs and other contents can be reprogrammed to overcome the burdensome aspects of selfhood and the implicit strategy of trauma re-enactment. Then, flexible, resilient schemas, which contain nonaddictive coping skills, can be incorporated in the evolving self.

CONCLUSIONS

Sadomasochism is the tie that binds overwhelming experiences of neglect and abuse through the re-enactment of trauma in addiction. Female survivors of life trauma discover sadomasochism as the solution to the paradox of their existence: avoiding the pain and shame of the past by becoming dependent upon symptoms that will not let them forget the crime. Trauma survivors subject themselves to ongoing brainwashing by means of the life trauma syndrome, especially the sadomasochism of eating disorder, self-injurious behavior, and sexual addiction. For women, sadomasochism reflects the convergence of their personal experiences with humiliation and soul murder and the gender role of inferiority prescribed by patriarchal society.

Perversion, as an eroticized form of hatred, captures the essence of damaged object relations in the childhood abuse experiences of many women. The blending of love and hatred imprisons them in altered states represented by addictive disorders and the other symptom complexes in the life trauma syndrome. Four basic part-personalities or ego states emerge over the course of development. The ego states (Dependent, Addict, Masochist, and Sadist) are organized around avoiding life trauma by replaying salient aspects of the abuse experience. In sexual sadomasochism, the bondage, humiliation, or pain reflect isomorphic, compensatory, or escapism subtypes. Other forms of sadomasochism, such as chemical dependence, self-injurious behavior, and eating disorder, function to manage stress, ward off depression, express anger indirectly, or bolster the fragile ego of a survivor fixated or regressed in an infantile stage of psychosexual development.

Women who develop addiction to survive life trauma attempt to overcome the coercive persuasion imposed by neglect or abuse by brainwashing themselves through sadomasochistic dynamics. They unfreeze, change, and refreeze habitual thought processes by means of exaggerated gender role-playing in an addictive lifestyle. By entering psychotherapy, a humane form of brainwashing, addicted survivors are able to instigate, reprogram, and contain life trauma. They overcome the oppression of trauma and addiction, recovering potentials for creativity, intimacy, and spirituality. There are instigation, reprogramming, and containment techniques for each of the four
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ego states across five themes or life domains (Safety, Trust, Hope, Power, and Love). In order to repair object relations damaged by neglect or abuse, survivors must abstain from addictive re-enactment, relive the pain and shame of the past, and return to that place in development where they were left or lost.

REFERENCES


