

Early Sexual Trauma Imprints: How the “Yuck” Factor Impacts the Victim

Melissa M. Bradley, MS, NCC, BCETS, FAAETS

We all have imprints – both positive and painful. Early in our development, we are taught - through repetition - how to love (or not) and how to interact with others. Dr. Gary Chapman’s many works on The Five Love Languages, explains that people register healthy love and validation through five ‘love languages’: acts of service, words of affirmation, gift-giving, physical affection and quality time. These would be examples of healthy love imprints.

On the other end of the equation, Dr. Jeffrey Young’s work on Schemas (www.schematherapy.com) would be examples of a form of emotional and cognitive (the way we think) negative or maladaptive imprints that are played out over and over throughout a person’s life...or until we consciously begin to undo the schema (or life trap).

When a child has been emotionally, physically, verbally or sexually wounded, what they learn is significantly different. Repeated trauma in early development creates a greater likelihood of a trauma imprint. A trauma imprint is a behavioral, physiological and interpersonal wound that can impact the traumatized for decades (or forever). When a person experiences a *sexual* trauma (i.e. incest, rape, molestation, and sexual abuse & exploitation) prior to reaching full sexual maturity, there is a greater likelihood there may be a sexual trauma imprint. If left untreated, this type of imprint can dramatically impact emotional and sexual intimacy, choice of partner and ability to trust.

The most common elements of a sexual trauma imprint are: fear, physical and sexual arousal, shame, secrecy, isolation and power issues –powerlessness and/or powerfulness. Intense fear is a staple of trauma and is part of what causes an event to be traumatic. Bessel van der Kolk, MD, a leading authority on the neurophysiology of trauma, describes a trauma as “a biological or physiology assault in which people may not be able to reset themselves.” As a child experiences the physiological results of trauma through the hyperarousal responses of flee and fight or a classically dissociative response of freeze, there will be shift in heart rate and respiration and muscle tension, and a triggering alert in the brain stem which floods the body with stress chemicals (such as cortisol and adrenaline).

Sexual arousal and sexual desire are different. Arousal is an automatic response the body exhibits, which can be conditioned to respond to certain stimuli. Sexual desire is the mental aspect...the “want to.” For child sexual trauma, a sexual desire (the want to) is rarely present and even if it is, sexual contact between an adult and child is still an inappropriate and illegal. There cannot be mental or emotional consent to sexual activity with a child. Since sexual assault or exploitation of a child is illegal in our culture, it usually occurs within parameters of secrecy and isolation, thus shutting the child and the offender off together in that abusive world. The profound sense of powerlessness a child usually feels furthers their vulnerability for future assaults. Because of the child’s lack of vocabulary and experience, they may simply call this experience “yucky.” The discrepancy between the desire and the arousal are confusing for the child and it may seem as if their body has betrayed them. This incongruence between arousal (body) and desire (mind) can often become a life-long issue.

One way to explain the difference between desire and arousal is: if a person was held down against their will and having something forced in their mouth, their anxiety level would be high. Next imagine that the “something” that was being forced into their mouth is sugar. Although there’s resistance, there may also be a pleasure response when the sugar makes contact with the tongue. Frequently, the body has an initial positive response to the early part of the assault. Most molestation occurs within the context of pseudo-cooperation, manipulation and coercion, rather than overt force, which is part of the problem. Intimacy in later life may become fraught with shame, emotional discomfort and confusion, even when there is an intellectual awareness that sexual intimacy with a mate is appropriate. One of the most common ways the incongruence is re-enacted is with inhibited sexual desire. Although a person’s partner may be able to “jump start” the sexual response, with loving caresses, the body responds and prepares for intercourse. There still may be a “yuck” factor present. After engaging in a sexual act (not perceived as making love to a person experiencing this), the “yuck” factor may cause the traumatized individual to feel shame. They may, once again, perceive the body has betrayed them.

A sexual trauma imprint may have specific personalized elements from the trauma. For instance: “Rose,” a 30-year old female, was molested by her father from the age of 4-12. The father’s beating of the mother always preceded molestation. Rose witnessed the violence while hiding under a table. After the beatings, the father would leave the house to get drunk, while Rose cleaned up her mother and the blood and when the father returned, he would molest Rose. This pattern occurred dozens of times during Rose’s early development. In addition to the imprints of fear, physical and sexual arousal, shame, guilt, powerlessness and secrecy, she also had trauma imprints of blood, violence, rage and predictability. As an adult, she would find herself sexually aroused when she would see violent movies or after being beaten by a boyfriend. She would immediately experience shame, wondering if she was “perverted” for her body responding sexually to such violence.

Another example is “Guy.” Guy suffered eleven, or more, years of molestation by his five brothers and many of his brother’s friends from the ages of 3 to 14. All of the assaults occurred in bathrooms – in the home and at community park. When Guy married and had a son, he began acting out his early trauma when his son reached the age of three. At that point, he began having nightmares, panic attacks and feeling overwhelmed. He began to have frequent anonymous sexual encounters, in public restrooms, with other men. His wife caught him during one of the anonymous encounters; she divorced him and a custody battle ensued. Guy’s presenting issue the first day of counseling in was questioning his sexual orientation.

The general public is often under the elementary assumption that sexual orientation is simply about being sexually aroused by a particular gender, which is part of what our orientation is, but sexual orientation is actually a more complex issue. The danger in making an assumption about orientation – based only on arousal patterns (and not considering emotional connections, fantasies, interests, etc.) is what occurs when there has been an early sexual trauma imprint. The sexual arousal or even phobic avoidance called sexual anorexia can occur as a part of a sexual trauma imprint and can distort the perception of sexual orientation although it *doesn’t change innate orientation*. Therefore, a person may struggle with the issues around what is perceived to be sexual orientation, if there is actually a trauma imprint. Trauma imprints and sexual orientation are not the same thing. Although there are similarities, the lumping of a trauma imprint with sexual orientation may traumatize the individual further.

There can also be times when those who seek treatment, because of confusion and questioning the possibility of being bisexual, *may* find there is an innate orientation combined with a trauma imprint. That is certainly not true for all who identify themselves as bisexual. The trauma imprint can be quite intense because it is fear, shame and power driven. A reactive orientation, or trauma orientation, can also occur when a person is abused by one gender and, while seeking to avoid a re-enactment of the trauma, “choose” the other gender. *This is not the same as innate orientation.*

During the early sessions with Guy, I explored his sexual history. It was during that time I found that Guy had been molested by all of his five older brothers and his brother’s friends and all of the abuse occurred in the basement bathroom in their home and the public bathroom near the community playground. The molestation continued for more than ten years. In his teen and early adult years, there was never any activity with males, he had no emotional (positive) interest in males, had no fantasies around males and it began to appear that Guy was probably not dealing with orientation questions as much as a trauma imprint.

If Guy had been older and at a more mature developmental level prior to his sexual trauma, then he might have had an awareness of his innate sexual orientation. Since the trauma began at such an early developmental level, he had not had the opportunity to gain this awareness. Working through the trauma, prior to processing orientation issues, is vital. For Guy, his sexually compulsive behavior also needed to be addressed prior to the orientation exploration. The trauma fragments need to be addressed prior to addressing arousal, desire and orientation issues, or clinicians run the risk of rewounding a client and the client identifying with a trauma-based orientation, rather than innate orientation.

The work to decrease a trauma imprint and to build new and healthy imprints require intense (and appropriate) focus on the trauma fragments, with a highly skilled mental health provider or a clinically certified sex therapist. The understanding and sensitivity about trauma imprints is an essential part of training for those working with the sexually wounded.

For more questions about sexual trauma imprinting, you may contact Melissa Bradley, MS, NCC, BCETS, FAAETS: 615-377-6002.

(This article is to be published in The American Academy of Experts in Traumatic Stress Journal)