International Journal of Advanced Studies in Sexology
© Sexology Institute of Romania
Vol. 2(1), 2020, pp. 9-14

https://www.sexology.ro/jurnal
ISSN 2668-7194 (print), ISSN 2668-9987 (online)
DOI: 10.46388/ijass.2020.13.12

SEXUAL AVERSION

CORINA-MIHAELA (TUDOSE) POPA

Faculty of Psychology of Titu Maiorescu University, Bucharest, Romania

Corresponding author email: corinamihaelatudose@gmail.com

Abstract

Sexual aversion is a phobic reaction often involving trauma, not necessarily related to sexual abuse or rape. It consists of avoidance of sex related stimuli that have been associated by the patient with distressing experiences. It leads to sexual dysfunction for either male or female, and it can have a tremendous impact on a person's life. This article investigates the etiology, evolution and factors the construct implies and explores some treatment considerations.

Key words: sexual aversion, lack of sexual interest, anxiety, sexual disgust.

INTRODUCTION

Sexual aversion is the effect of past traumatic experiences involving the body: history of physical, sexual and emotional abuse (with chronic PTSD associated symptoms), unresolved internal conflicts concerning sex and sex related behaviors, improperly integrated gender identity, emotional discomfort with pleasure, negative beliefs about gender role, femininity/masculinity. It is often defined as a phobic reaction depending on its severity, or at least it is associated with anxiety and correlated discomfort.

The notion implies the reluctance in engaging in sexual activities and an overall decrease in sexual interest and drive. It is triggered by cognitions, actual life situations and it can vary in severity, with extreme levels of panic, disgust and revulsion (Foley *et al.*, 2012). It results in either the absence of sex (eroticism and sexuality are repressed and excluded from the individual's conscious life) or in dissociative sex or acting outs (in the event sex cannot be excluded entirely, the emotional experience is nevertheless numbed). The prevalence of sexual aversion is difficult to trace because such patients avoid couple and sex therapy, unless there is pressure by the partner (Metz *et al.*, 2018). Once diagnosed, it is relatively difficult to address in conventional forms of therapy.

Theoretical perspectives

When first included among the DSM dysfunctions in 1987 in DSM – III – R (American Psychiatric Association, 1987), sexual aversion received the following definition „persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner".

DSM-IV-TR (American Psychiatric Association, 2000) extended the definition and stressed the idea that (even the perspective of) having any sexual contact was associated with fear, anxiety, and disgust. Also, a wide range of stimuli and behaviors were meant to evoke aversion, ranging from a very specific aspect related to sexual intercourse (e.g., genital fluid) to almost all stimuli or behaviors that may be involved in sexual activities (kissing, touching,

cuddling included). Symptoms of (extreme) anxiety/panic and avoidance behaviors were described as signs of severe sexual aversion. Interestingly enough, DSM-IV-TR also indexed another dysfunction which dealt with hypoactive sexual desire (Hypoactive Sexual Desire Disorder, HSDD), which is not limited to sex with someone else, but is also related to having less sexual desire, fantasies, and urges to self-pleasure.

As DSM turned the page and reached its 5th edition, sexual aversion disappeared from the list of sexual dysfunction, which is quite interesting as it surely did not disappear from people's lives.

The why might be explained by a theoretical struggle between specialists regarding the nature of the problem. Questions arose: what is the nature of sexual aversion? And the answers taken into consideration were phobic related, or sexual cored. Another aspect that needed to be investigated were the differences between this construct and HSDD. Because there was not enough evidence to support sexual aversion as a distinct category, researchers returned to studying its roots.

Mary Kaplan in 1987 explained the phobic characteristics of sexual aversion. Consistent with this conceptualization, individuals diagnosed with SAD (Sexual Aversion Dysfunction) are known to avoid of all shapes and forms of sexual contact within a large spectrum. In addition, fear, anxiety, and disgust, have been considered prominent features of aversion in the DSM-IV-TR, which further stresses the similarities between specific phobias and SAD.

As far as research is concerned, there is one study quoted on the subject which involved 4.147 subjects. The sample is considered representative for the adult population of Netherlands, ages 19 – 69. Performed online by Bakker & Vanwezenbeek, 2006, *apud* Borg *et al*, 2014 it used a validated DSM-based questionnaire and demonstrated that over 30% of the participants reported experiencing sexual aversion at some point in their lives, out of which 4% met the criteria for SAD. In terms of prevalence the percentage were similar to those related to dyspareunia (5 %). Moreover, women between 15 and 40 years reported significantly more often to have (symptoms of) sexual aversion than women above 40 years of age. This is in line with what one would expect, as disgust responding and corresponding avoidance decreases with exposure to unpleasant stimuli. This also means that as they age, most women tend to get accustomed to the stimuli in question.

When investigating the possible link between disgust and sexual aversion, there is an increased interest on the subject (de Jong, & Weijmar-Schultz, 2010 *apud* Borg *et al*., 2014). For instance, Rosen et al., 2000 proved that low sexual functioning as measured by the Female Sexual Functioning Index was associated with relatively high disgust for sex relevant stimuli. The correlation did not confirm for men. A follow-up study showed that women with vaginismus (a DSM-IV-TR based diagnosis) scored higher on sexual disgust than women without sexual problems. On the other hand, sexual disgust was absent in women with dyspareunia (van Overveld *et al*., 2013 Study 2 *apud* Borg *et al*., 2014). This may be due to the actual focus in this particular dysfunction. Fear of pain tends to be more important than aversion at the prospect of actual intercourse. Congruent with the idea that disgust might play a role in vaginismus, women with such diagnose also showed relatively strong activity of the disgust-specific facial muscle while watching adult sexual content (Borg *et al*., 2014).

Trauma related literature has regarded sex aversion as a direct consequence of disturbing and highly overstimulating interpersonal experiences. There is considerable evidence that women who experience physical and sexual abuse commonly develop sexual dysfunction. Their sense of safety, their ability to trust a potential intimate partner, their willingness to open up and talk about their traumatic experience is undermined by feelings of guilt, shame, fear of rejection. As if it wouldn't suffice, traumatic experiences are usually topping internal conflicts regarding sex. There might be issues concerning low self-esteem, poor body image, inaccurate or unrealistic sexual cognitions, internal ambivalence or conflict

regarding the sexual self, fear of intimacy, and discomfort with the concept of pleasure.

Another root to the problem might be the dissociative solution some people find with regard to their sexual behavior. One possible take out is the isolation of the affect when it comes to sex (the individual protects himself by distancing the consciousness from the body) or acting out practices (for instance latent homosexuals who engage in heterosexual relationships avoiding sex, also have a secret homosexual active life). The picture can widen when there is an actual physical response in the body that ties sexual activities with discomfort and/or pain (male and female dyspareunia, vaginismus) or there is a physiological problem that needs to be addressed with the help of the MD.

As a defense meant to word off emotional conflict regarding sexuality, many people reject sex entirely. They don't self pleasure, they are out of contact with their body and can prove unexperienced and fearful when it comes to remediation of sexual skills. Guilt and shame become of huge importance. Guilt has been of central importance to an understanding of mental life since Freud proposed it as the precursor of conscience. Psychoanalytic writers have emphasized that guilt plays a healthy role in shaping people's values and capacity to love, while also noting that an excess of guilt - particularly unconscious guilt - can contribute to problems as diverse as depression and psychosomatic diseases.

Therapeutic challenges

As stated above, once diagnosed sexual aversion proved to be very difficult to address in the clinical practice. There are a number of choices.

CBT, for instance which is used with positive results in the common treatment for sexual dysfunction could be an option for both individual therapy as well as group support.

In the core interventions for sexual aversion in individual meetings a therapist can rely on cognitive behavioral strategies adapted from anxiety and anxiety related protocols. There are many directions to follow depending on the aim of the treatment:

1) Strategies that target a reduction in fear (of penetration, sex related anxiety):

a. CBT for fear related cognitions.
b. Exposure therapy targeting behavioral avoidance (anxiety protocols).
c. Systematic desensitization using behavioral hierarchies of sexual activities (to reduce anxiety before addressing arousal or orgasmic issues).
d. Mindfulness-based interventions - increasing awareness of sexual responses, decreasing judgment toward these responses, and reducing the effect of distractions (by viewing them as mental events not necessarily needing to be attended to).

2) Avoidance behavior.

Although anxiety and fear are mentioned to play a role in sexual dysfunctions, and treatment efficacy supports the use of CBT targeting relevant fears and anxiety, it would be useful to better understand the specific effects of anxiety on sexual avoidance to identify specific mechanisms that can be addressed in the clinical practice. For example, reduction in coital fear among women with vaginismus is changed through addressing avoidance behavior.

Cognitive models that incorporate individual differences with regard to beliefs about anxiety and sexuality may be useful in explaining the diversity of situations confronted by the therapist.

A combined diagnostic approach, examining individual differences in belief systems can help expand our understanding of the etiology of sexual dysfunction and lead to the development of interventions that are based on established research findings rather than clinical intuition. As far as anxiety and sex are concerned, correlational analysis suggests that anxiety sensitivity is associated with greater sexual functioning difficulties in both women (Gerrior, Watt, Weaver, & Gallagher, 2015) and men (Tutino, Shaughnessy, & Ouimet, 2018). Experimental research manipulating anxiety sensitivity (by inducing beliefs about physiological sensations and their consequences) is needed to determine whether and to what extent anxiety sensitivity

determines sexual avoidance and other aspects of sexual response.

Returning to the privacy of the therapist's office, the patient needs to learn how to relax and develop a sense of safety, empowerment, as well as skills to manage the phobic reaction (mindfulness techniques). A progressive approach is using sensate focus which allows the patient to develop a connection with his body and stay in the moment, wording off anxiety and having a complete sense of control over the sexual encounter (Weiner & Avery-Clark, 2017). This way the client relies on a good base for developing a sense of safety and an increased interpersonal connection to the partner. Awareness of pleasurable sensations is important, as the patient needs to disconnect the brain wiring from the traumatic associations. This way, as his mind recognizes the experience as being good, it will allow access to it, further exploration as well as a diminished stress response.

While doing cognitive restructuring of the anxious associations to sex, behavioral strategies help developing skills modify aversive reactions as well as build an authentic intimate relationship with the partner.

Another approach is group CBT therapy consisting in sex education; couple sexual intimacy–exercises; sensate focus; communication skills training; intimate communication skills training; sexual fantasy training; cognitive restructuring; and various homework assignments, including relevant readings. Literature also mentions orgasm consistency training which might comprise of directed masturbation literacy; ''ladies cum first'' rules; and the use of CAT (coital alignment technique) to ensure direct clitoral stimulation by the penis during intercourse. All this can be used after the tolerance to sexual stimuli has grown and a sexual encounter isn't seen as threatening as initially was.

Sometimes, teaching someone how to do things right and working with cognition isn't a predictor for success. Usually, traumatized people understand perfectly what they need to do in order to address their sex issues, but the traumatic affect remains unaddressed and lost in translation. This is where individual/group trauma therapy, or talk therapy may be a more appropriate choice, because this way the traumatic content itself can be emotionally integrated.

When overwhelming stressors occur acutely or chronically, there is a natural response of the body and mind (both physiologically and psychologically) which implies numbing, avoidance, amnesia and anhedonia bypassed by sporadic presences of affect and memory, hyper reactivity to stimuli and traumatic re-experiencing (Horowitz, 1986).

The numbness is about avoidance, detachment, emotional constriction and depression. Because of the high level of fear a traumatized person gradually revisits the event for limited periods of time, either directly or indirectly, until it is mastered or integrated. The link between trauma and sexuality is mediated by the phenomenon of dissociation.

Dissociation is a safety-oriented cognitive mechanism in which the individual attempts to avoid memories or affect that alter the psychic equilibrium. With dissociation there may come reality detachment – isolation of affect, events are perceived without emotions, the self becomes robot-like and others are seen as emotionless objects. Thus, dissociation serves the function of creating a distance, an empty space between the traumatized person and the rest of the word since closeness and/or dependency may be seen as dangerous by the traumatized person.

Also, distancing oneself allows the individual to maintain the depersonalized state, and therefore not think or feel about past traumatic events. Braun (1988) has conceptualized dissociation of behavior, affect, sensation and knowledge (or cognition) as the BASK model. As far as the compulsive behavior is concerned it becomes a reenactment of the original trauma. A part of self will revisit the experience of the abuse time and time again, to repeat the danger and excitement, in an attempt to complete the flight, fight, freeze response cycle.

Dissociation of affect might include experiencing terror, numbness or confusion without any apparent cause, or affect not correlated to

the present situation. Dissociation of sensation may include numbness, headaches or sickness or pain in the physical body with no medical explanation.

The sensations of the body with sexually traumatized people are particularly subject to dissociation because of the irrational belief that the body is responsible for their misfortune. It's because of my gender /sex role / body / femininity that I was abused. Other examples of dissociation are the out-of-body experiences (while having sex the individual "leaves" the body and watches from above/the side, thus feeling numb). The cognitive system shuts down, and the individual then disengages each time he or she has sex lending the "body" to the partner.

Another critical component of dissociation is fragmentation of personality and the self. Whenever a traumatic situation occurs, the event is entrapped by the dissociative process and separated from the rest of a person's life. There is some exchange of information with the external reality and memories come back as flash-backs or dreams.

Typically, when there is severe early trauma, a part of the self becomes a machine that has endured the abusive experience, and another one holds the affect: rage, sadness which cannot be expressed. Because of the splitting in personality, which once allowed the survival of the individual, the here and now self might struggle among conflicting needs. These parts of self may act autonomously encouraging self-destructive behavior. That's why obsessions and compulsions provide a relief from the pain of disconnection and chronic dysphoria.

The acting-out behavior and re-victimization of self is a form of masochism, known to be one of the long-term effects of severe early abuse and neglect. Ultimately, resolution of past trauma and integration of the split off parts of self are essential to stop the self-destructive behavior.

CONCLUSIONS

As often the case with sexual dysfunction, the best approach to the problem is a combined effort to develop and awaken the hidden resources of the patient asking for help. Cognitive, behavioral, pharmacologic or talk therapy treatment options are helpful to reduce the aversive response to sexual cues. Because sex aversion quickly becomes a relationship breaker, the full support and engagement of the partner is a must.

Numerous studies Delcea C, Enache A, Stanciu C, [17], Delcea C, Enache A, Siserman C. [18], Gherman C, Enache A, Delcea C. [19], Delcea C, Fabian, A. M., Radu, C. C, Dumbravă D. P. [20], Rus M., Delcea C., Siserman C, [21], Siserman, C., Delcea, C., Matei, H. V., Vică M. L. [22], Gherman, C., Enache, A., Delcea, C., Siserman C., [23], Delcea C, Siserman C, [24] confirm our results. The members of the couple collaborate to engage in positive and affectionate sexual expression, working as an intimate team to counteract conditioned traumatic responses (Calhoun & Tedeschi, 2006).

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