Chapter 3:
An Epidemic of Shame: Non-Contact Sexual Abuse

Most of us are less masters of self than slaves to shame.
—Donald L. Nathanson[1]

Patrick, a high school and college seminary classmate of mine, was 26 years old when he put a .38 magnum revolver in his mouth and pulled the trigger, blowing the back of his head off and splattering his brains against the wall of his apartment. I didn't see the suicide scene, but Pat's roommate's description is permanently etched in my memory.

Pat was a class clown in the Borromeo Seminary High School class of 1967, with a sense of humor worthy of Monty Python's Flying Circus. His "Padre Pio Miracle Kit"—guaranteed to duplicate the famous miracles of the wonder-working Italian priest—became a class legend.

I could tell even in high school that Pat's jokes were camouflage for a fundamentally unhappy young man. I didn't stay in touch with him after he left the seminary, but from mutual friends I heard about some of the milestones in his life: he had begun a promising career in social work; he had a girlfriend who wanted to marry him, but he wasn't ready; he was going to a Freudian psychoanalyst.

I was shocked when I got the phone call telling me that Pat had killed himself. I knew that something was wrong in his life, but I couldn't imagine how it could be so bad that it would drive him to suicide, especially when he seemed to be getting the best counseling available, both religious and secular.

As a priest, I joined most of my classmates at Patrick's funeral mass. It was there I learned that he had left a suicide note: "I'm sorry. I was unable to love." The explanation was as puzzling as the act. Certainly Pat was self-absorbed at times, but when he turned his attention to others he was generous and caring. It seemed to me that Pat's ability to love was at least average, and probably higher. Everyone at the funeral seemed to share my ignorance of why Pat killed himself. If anyone had any idea why it happened, no one was willing to say it out loud.

It was many years later when I learned the fact that explained Patrick's suicide: he was gay.

Once I knew that, all the pieces of the puzzle fell into place. Of course he wasn't ready to get married. I remembered being told that after two years of psychoanalysis, Pat felt his problem—whatever it was, I wasn't told—had not been solved. In other words, his sexual orientation could not be changed. And finally his suicide note, "I was unable to love," made sense. He was unable to love in his own way. Or, to be more precise, his church and society would not allow him to love in the way that was natural to him. Pat's comedy act seemed to be motivated by a desire to be loved. But the harassment that gay men and lesbians face in our society must have convinced him that he could never be loved for who he really was.

Patrick's real problem was not homosexuality but pathological shame, the feeling "that one is at core a deformed being, fundamentally unlovable and unworthy of membership in the human community."[2] For someone suffering from excruciating shame, the only apparent solution is to become nonexistent.[3] Suicide is the literal enactment of what shame sufferers sometimes feel they deserve.

Of course, pathological shame is not unique to homosexuals, and its effects are not always as dramatic as suicide. According to psychologist Robert Karen, "Many psychologists now believe that shame is the preeminent cause of emotional distress in our time."[4] Shame has been linked to aggression, addictions, obsessions, narcissism, depression, anorexia, bulimia, and many other disorders.

The relationship of pathological shame to sexuality is most clearly seen in cases of sexual abuse. "Sexual and physical abuse," says therapist Gershen Kaufman, "are guaranteed by their nature to produce excessive shame, beyond the capacity of the individual to tolerate—anytime the body is violated, that always leaves the person defeated and humiliated."[5] John Bradshaw adds that sexual violation "amounts to the violation of one's very being, since sexuality is something we are, rather that something we have."[6]

An Introduction to Shame

Shame is the source of a family of emotions that go by names such as shyness, embarrassment, inhibition, humiliation, mortification, unworthiness, abashment, chagrin, disgrace, dishonor, discouragement, and low self-esteem. Unlike guilt, which is a feeling about actions, shame is a feeling about our inner self. It makes us feel incompetent, inadequate, inferior, incomplete, defective, unloved, and unlovable. The social dimension of shame is a loss of status, which may range from momentary embarrassment to ostracism.

The polar opposite of shame is pride. Pride can be a sense of achievement over something we have done, but it is also a positive feeling about our self, a feeling of competence, completeness, self-respect, self-satisfaction, self-confidence, worthiness, dignity, lovableness, and self-esteem. Popular discussions of self-esteem often trivialize it by ignoring its opposite, shame. When you realize that being ashamed of yourself is the alternative to self-esteem, you can see how serious and important self-esteem is.

Shame is such a painful emotion that most people find it difficult even to think about, much less discuss in public. Even psychiatrists and psychologists generally ignored shame until the last few decades, when it began to receive more widespread attention. One of the most important studies of shame, and the source for most of what I will say about shame in this book, is *Shame and Pride: Affect, Sex, and the Birth of the Self,* by Donald Nathanson. Nathanson's understanding of shame is grounded both in his clinical psychiatric experience and in the research of experimental psychologist Silvan Tomkins, who spent his career studying the affect system, the biological foundation of human emotions.

The Biological Basis of Shame

Nathanson compares the human emotional system to a personal computer made up of hardware, firmware, and software. In a computer, the hardware consists of a microprocessor, memory chips, disk drives, input/output devices, etc.; the firmware is the built-in or "hard-wired" instructions that tell the components how to work together; and the software is all the programs that make the computer perform various tasks. In the human emotional system, the hardware would include the central nervous system; the muscles controlling face, posture, and vocalization; and the glandular system. Our emotional firmware consists of affects and drives. And our emotional software consists of experiences, learning, social conditioning, and memories. Nathanson defines psychotherapy as the art of locating and fixing programming errors in human software.

Emotions can originate in any of the three subsystems. Nathanson gives this example of some possible origins of fear:

> We can be frightened when accosted by a thief in the night, by an otherwise inaccessible memory hidden within the unconscious, by an inborn error in metabolism that produces "fear chemicals," and by any number of medications taken into the body for other purposes.[7]

Each emotion, whatever its origin, is characterized by some combination of thoughts and somatic feelings, such as sweating or changes in breathing and heart rate.

The term *affect* is defined differently by different schools of psychology, but for Tomkins and his followers, it is the strictly biological aspect of emotion:

> When we say that an affect has been *triggered,* we mean expressly that some definable stimulus has activated a mechanism which then releases a *known pattern of biological events.* Each of the innate affects unfolds according to its own precisely written program. Each one lasts a strictly determined period of time, ranging from a few hundredths of a second to a couple of seconds.[8]

It is important to remember that affects are automatic, involuntary physical responses to specific stimuli. When the stimulus occurs, there is no way to prevent the affect response.

The shame–humiliation affect is triggered whenever there is an impediment to the expression of either of the two positive affects, enjoyment–joy or interest–excitement. (Tomkins labeled most affects with two words to express the possible range of intensity.) The outward manifestation of shame is easily observed—the eyes and head turn down and away, and the neck and shoulders begin to slump. For example, imagine yourself walking down the street when you think you spot a friend whom you haven't seen for a long time. Excited, you call out your friend's name. When the person does not respond, you realize it is not your friend but a look-alike. You turn away and look down, feeling embarrassed. This reaction is universal and automatic, "hard-wired"—that's what makes shame an affect. Every time we experience an impediment to enjoyment, interest, or excitement, our bodies experience shame.

When we become aware of an affect, it becomes a feeling. In our example, embarrassment is the feeling that comes with the shame affect. But sometimes we're not aware that an affect has been triggered, especially if the affect is shame. Most of us don't recognize shame as one of the major

ingredients in our depression, discouragement, frustration, unhappiness, loneliness, or boredom; nor do we notice that shame is often the trigger for anger. But even when we're not consciously aware of shame, even when we can't feel it, it may be present as a biological reaction.

As we accumulate experience, an affect becomes intertwined with memories of what triggered the affect and what followed the reaction. These memories can become triggers for further affects. This complex combination of affects and memories is what we call emotion. Affects are unvarying physiological mechanisms that become emotions when placed in a script or story. Affects are impersonal and biological; emotions are personal and biographical. An affect lasts a few seconds, but an emotion lasts as long as we keep finding memories (or producing chemicals) that continue to trigger the affect. When the emotion lasts for hours, days, or longer, it becomes a mood. Negative moods may come from unresolved problems or biochemical disorders.

By studying the facial expressions of babies, Tomkins was able to identify nine innate affects. These include two positive affects: interest–excitement and enjoyment–joy; one neutral affect, surprise–startle; and six negative affects: fear–terror, distress–anguish, anger–rage, dissmell, disgust, and shame–humiliation.

Shame–humiliation is the most recently evolved and complex affect. While the other affects simply amplify a specific neurological stimulus, shame amplifies an impediment to one of the positive affects while the stimulus for the positive affect is still present. Not an easy concept to understand at first.

Here's an example: A boy in a convenience store notices a pornographic magazine on a rack behind the counter. Interest–excitement focuses his attention on the cover photo of a naked woman, which triggers enjoyment–joy. The boy may continue enjoying the erotic mental image after leaving the store until something else attracts his attention; then the mental stimulus and the enjoyment disappear. But if the female clerk in the store, a friend of his mother, sees him staring at the erotic photo, that's an impediment to his enjoyment. Shame amplifies that impediment, causing the boy to look down and turn away. The function of shame is to block a positive affect while the positive stimulus continues. Thus shame is a source of painful inner tension.

When shame becomes a chronic condition, it can be emotionally and even physically debilitating. Tomkins described shame as a "sickness of the soul":

> Shame is the affect of indignity, of transgression and of alienation…. Shame strikes deepest into the heart of man. While terror and distress hurt, they are wounds inflicted from outside which penetrate the smooth surface of the ego; but shame is felt as an inner torment, a sickness of the soul…. The humiliated one … feels himself naked, defeated, alienated, lacking in dignity or worth.[9]

"Shame feels so miserable," Nathanson adds, "because it interrupts what feels best in life."[10] Shame occurs whenever desire outruns fulfillment, and is, therefore, an unavoidable part of life. The stronger the unfulfilled interest or enjoyment, the more painful the shame. To the extent that we seek pleasure, we must experience shame. Shame is inevitably associated with sex, because

our sexual desires so far surpass what we can realistically enjoy. The fulfillment of all our desires would eliminate shame. Shame has no place in paradise.

Competence, Pride, Shame, and Self-Image

From the moment of birth, an infant is faced with a series of developmental challenges, some of which I will describe in Chapter 6. In general, these challenges include learning to use and master sensory perception, bodily motion, emotion, learning, and interaction with other people. The key issues of interpersonal relations are bonding versus separation, or dependence versus independence. When an infant's basic needs are met and the infant masters its sequential developmental tasks, each success brings a feeling of competence and pride that is incorporated into the infant's self-image. These successes—or failures—actually create one's identity.

Empathy, the most basic human relationship skill, is crucial to an infant's emotional development. If caregivers are attentive to an infant's feelings and respond to them, meeting his or her physical and emotional needs, the infant feels loved. Parental empathy enables the infant to bond successfully with the parents and achieve the appropriate level of separation and independence at each developmental stage. These fortunate infants develop a strong sense of identity and high self-esteem.

But if caregivers do not respond to an infant's feelings, he or she experiences shame. This infant learns to interpret the adults' failure to respond as his or her own failure. If the adults continue to be unresponsive and emotionally abandon the infant, distress, fear, and anger are added to the infant's shame. When empathy is routinely withheld, the infant does not develop this most basic relationship skill. Feeling incompetent at relationships, unloved and unlovable, the child grows up feeling incompetent as a person. Failures of bonding and separation create an insecure, weak, or confused identity. With no foundation for a healthy sense of identity, such people are literally ashamed of *themselves.* Shame becomes the core of their identity and an obstacle to intimate relationships. As Nathanson observes, "Shame interrupts affective communication and therefore limits intimacy and empathy."[11] As we saw in the last chapter, this is the typical childhood of the sex offender.

Life is an unending series of challenges with potential for success or failure, so self-esteem is always at risk. But early childhood sets the pattern for the rest of life. Children who develop a strong identity tend to be more successful and to learn more easily from their failures, thus maintaining their self-esteem throughout life. Children with a weak identity and low self-esteem tend to fail more often and have difficulty recovering and learning from failures. The cycle of failure and shame is self-perpetuating.

When our personal identity is based more on shame than pride, we look for momentarily relief wherever we can find it. Nathanson comments:

> Arrogance, haughtiness, disdain for the accomplishments of others, jealousy, envy, and greed are only a few of the defensive attitudes and emotions that characterize those for whom self-awareness is more painful than pleasant. For those whose lives are ruled by shame, anything that can reduce

> the self-esteem of others can assist them to feel better about themselves in relation to those others.[12]

From this perspective it is clear that the control and degradation of another person through sexual aggression can provide temporary relief from shame. Sexual abuse is frequently an attempt to relieve shame by transferring it to someone else. But there are many other defense mechanisms for deflecting the emotional pain of shame. Nathanson has organized these defensive scripts into four general strategies which he calls *the compass of shame*.[13]

The Compass of Shame

The four defensive strategies in the compass of shame (like the four directions of a compass) are *withdrawal, avoidance, attack self,* and *attack other.*

Withdrawal strategies may range from speechlessness to social isolation to severe dissociation. Sexual manifestations of withdrawal include sexual aversion disorder, impotence, and frigidity. *Avoidance* strategies are more external ways to avoid feeling shame; they include addictions, compulsions, distractions, workaholism, hedonism, and even sociopathy. In sexual avoidance, nonrelational sexual activity, often compulsive, is used to mask the fear of being unloved or unlovable.

Attack-self strategies include excessive self-criticism, self-ridicule, submissiveness, and masochism, including sexual masochism. *Attack-other* strategies run the gamut of aggressive behaviors from ruthless competition to ridicule to physical and sexual assault.

Many people seem to favor one direction in the compass of shame over the others. We do not know whether these tendencies are innate, learned, or (most likely) a combination of the two. But the compass of shame helps us understand why some victims of sexual abuse become perpetrators, while others do not: *attack other* is only one of the four ways of defending against shame.

All four strategies may provide temporary relief from the pain of shame, but they do nothing to heal it over the long term. Approaches to healing shame will be discussed in Chapter 7.

Shame and Interpersonal Boundaries

If shame can be so harmful, why does it exist? It exists to help us get along with other people. Much of our social life is organized around sharing activities that involve the positive affects, interest–excitement and enjoyment–joy. Shame puts a damper on positive affects when the triggers for those affects might be viewed negatively by another person or group. As we saw in earlier examples, shame squelches excitement when you realize you have mistaken a stranger for an old friend, and shame extinguishes pleasure for a boy looking at a picture of a naked woman when he realizes he might get caught and face criticism or punishment.

Shame serves as the border guard that protects boundaries between self and others. The border guard works in both directions, protecting social norms as well as individual privacy and integrity.[14] Shame prevents us from doing things that violate our society's norms of morality or respectability; thus it protects social boundaries. Shame also prevents us from doing things that violate our own personal values, or from allowing others to do things that violate our privacy, dignity, integrity, and identity; thus it protects personal boundaries. For example, shame keeps our clothes on in most public places, protecting us from the distraction of other people's bodies and from intrusive looks at our own body.

Healthy shame is always *situational*—it arises in response to a particular situation and disappears when the situation changes. If a friend whispers to me that my fly is open, I feel embarrassed, zip up my fly, and the shame disappears. No problem. Shame becomes a problem when it's long-lasting or chronic. Chronic shame, because it interferes with positive affects, reduces our emotional and physical vitality, impedes interpersonal communication, and robs life of its joy. When the positive affect interest–excitement is chronically inhibited by shame, we literally lose interest; curiosity disappears and boredom becomes a way of life. Shame also inhibits the functioning of the cerebral cortex, where rational thinking is performed. When you suddenly find yourself confused and unable to think, you may be experiencing a shame attack.

Paradoxically, healthy shame promotes both conformity and individuality—keeping the right balance is the key to healthy shame. The two functions of shame, protecting the group and the individual, often come into conflict when personal values and social values differ. How we handle those conflicts is the measure of our character.

America's current "culture wars" over sexuality are really about where to post the boundaries for shame to protect. Traditional sexual morality, based largely on an ancient ethic that treated women and children as the property of men, is strong on the issue of social boundaries, because historically it had to protect men's sexual property; but it completely disregards personal boundaries, which is why it can so easily lapse into sexual abuse. As a culture, we have yet to embrace a sexual ethic that achieves a good balance between personal and social boundaries. (I will present my own thoughts on sexual ethics in Chapter 10.) In the remainder of this chapter, I will describe how traditional sexual morality promotes chronic shame and actually encourages the violation of personal boundaries.

Non-Contact Sexual Abuse: Unacknowledged Aggression

Non-contact sexual abuse is a term sometimes used to describe behaviors such as verbal sexual harassment, exhibitionism, or emotional incest, which do not involve genital contact. Because it involves little or no physical contact, some people erroneously believe that non-contact abuse is relatively harmless. Nothing could be further from the truth. Sexual harassment, for example, can reduce self-esteem; cause depression, anxiety, and psychosomatic illnesses; and interfere with normal social, work, and educational activities. Even psychotherapists sometimes fail to realize that the effects of non-contact sexual abuse, depending on the victim's sensitivity, can be as severe as the effects of rape or molestation. I believe that shame is the primary source of the damage caused by both contact and non-contact sexual abuse.

My own life experiences and observations, conversations with other people, and reflections on the nature of sexual abuse have convinced me that we need to expand our definitions of non-contact sexual abuse. We will never be able to prevent sexual abuse until we recognize the patterns of abuse that are ingrained in our society, and work to change those patterns. Therefore, I am expanding the definitions of sexual abuse in order to develop a consistent ethic that respects personal boundaries and autonomy.

Table 1 lists a variety of behaviors recognized as abusive by experts in the field, as well as two categories I have added: *aversive sexual abuse* and *negligent sexual abuse,* which I will describe below. As you read over these definitions, you may recognize behaviors that you have never considered sexual abuse. This is the legacy of our moral tradition's blind spot for sexual abuse: many of us don't know how to identify sexual abuse, even when we are its victims.

Table 1
Varieties of Non-Contact Sexual Abuse

Aversive sexual abuse	Instilling an aversion to sexual pleasure or to harmless, consensual sexual behaviors through shame, guilt, or fear; vilifying and suppressing children's normal sexual interests and age-appropriate activities; using physical, legal, social, economic, or psychological coercion to prevent harmless, consensual sexual activities, thus violating personal autonomy.
Emotional incest	Sexualized or romanticized bonding between parent and child. The child becomes the emotional equivalent of a spouse and takes responsibility for the parent's emotional well-being. Playing this role interferes with satisfaction of the child's own developmental needs.
Erotic overstimulation of children	Creating an environment where inappropriate sexual stimulation interferes with a child's ability to master other developmental tasks; e.g., repeatedly exposing children to sexually explicit conversation or jokes, pornography, or exhibitionism.
Exhibitionism	Deliberate display of genitals, nudity, or erotic behavior to a child or a non-consenting adult for the purpose of the sexual or emotional fulfillment of the exhibitionist or the humiliation of the viewer; engaging in sexual activity in the presence of a child or erotic and seductive behavior toward the child. Nudity per se is not exhibitionism unless it is erotic, seductive, or intrusive.
Gender role/identity abuse	Creating an environment of hostility, inferiority, or ridicule toward either females or males, or toward a particular sexual orientation; criticizing, ridiculing, or punishing a child or adult for their sexual orientation or for not conforming to stereotyped gender role traits and behaviors; instilling fear, anxiety, shame, or confusion in a child or adult regarding their sexual identity or orientation; treating a child like a member of the opposite sex (e.g., making a boy wear girls' clothes).
Negligent sexual abuse	Failure to give children accurate and adequate information and moral instruction about sexuality at appropriate ages; failure of parents to model healthy attitudes toward sex, love, intimacy, and physical pleasure; failure to give children emotional empathy and physical affection.
Non-contact sexual sadism	Any form of non-physical abuse combined with deliberate intent to inflict extreme emotional pain, fear, disgust, or humiliation.
Non-physical invasion of privacy	Intrusive questioning regarding sexual feelings or behavior; making inappropriate or unwanted sexual advances; sexually explicit conversation or joking with a person known to be easily embarrassed or offended; deliberately exposing such a person to sexually explicit materials.
Physical invasion of privacy	Deliberate violation of another person's privacy boundaries regarding nudity, bathing, or toilet use, either by intruding on them or by failing to ensure one's own privacy, but without conscious erotic intent. Privacy standards vary between cultures, families, individuals, and situations; for example, in the U.S., nudity is appropriate at a clothing-optional beach or resort but not at the neighborhood swimming pool. Sensitivity to other people's feelings is the key criterion.

Verbal sexual harassment	Humiliation or ridicule of one's gender, sex organs, body size or shape, sexual feelings, sexual orientation, or character traits or behaviors contrary to stereotyped gender roles. Verbal abuse can easily be distinguished from teasing by the reaction of the recipient: if the recipient is amused, it is teasing; if not, it is abuse.
Voyeurism	Viewing or photographing the nudity or sexual activity of a child or a non-consenting adult for the purpose of the sexual fulfillment of the voyeur or the humiliation of the victim; erotic leering at a child or a non-consenting adult, whether nude or clothed. Intrusiveness distinguishes voyeurism from innocent looking.

Aversive Sexual Abuse

I define aversive sexual abuse as instilling an aversion to sexual pleasure or to harmless, consensual sexual behaviors through shame, guilt, or fear; vilifying and suppressing children's normal sexual interests and age-appropriate activities; or using physical, legal, social, economic, or psychological coercion to prevent harmless, consensual sexual activities, thus violating personal bodily autonomy. Aversive sexual abuse usually poses as enforcement of social boundaries regarding sexuality, but it crosses the line into violation of personal boundaries.

Children, for example, need to be taught their society's boundaries for sexual behavior. We don't want children playing doctor on the front lawn or masturbating in the supermarket. Empathetic parents can teach these lessons without inflicting excessive shame by telling children that these are enjoyable activities but that some people might feel uncomfortable if they're done in public, so it's better to wait until you have some privacy before enjoying your bodies in these ways. This kind of teaching fosters healthy shame, and the children can look forward to resuming their sexual play at a more appropriate time and place.

The abusive parent's approach to this situation is to say something like, "That's disgusting. Don't ever let me catch you doing that again." Even worse would be to punish the child or threaten punishment. That approach violates the child's boundaries. Sexual feelings and activities are a natural part of human life at every age. To label these feelings as dirty, shameful, or sinful is to impose chronic shame, with all its adverse consequences.

Sexual shame, as we saw at the beginning of this chapter, is a particularly severe kind of shame because sexuality is a core element of our identity. Sexuality is how we love; to shame a person sexually is to shame and impair that person's ability to give and receive love. Remember that shame is an automatic reaction whenever interest or enjoyment are blocked. It doesn't matter how "nicely" a parent tells a child that sexual pleasure is forbidden—the idea itself is abusive, because the child will feel the shame that comes from blocking a positive affect every time he or she experiences sexual pleasure.

We will see in Chapter 6 that sexual activity is an essential part of a child's physical, emotional, social, and psychological development. Doing something that interferes with or impedes a child's development is the very definition of child abuse. Unfortunately, even loving parents with the best intentions, if they are afraid and ashamed of sex, transmit that fear and shame to their children. Teaching children that they have no right to sexual feelings or activities, as traditional morality requires, in inherently abusive. It makes children feel defective, ashamed of themselves,

and fearful of God's punishment. The problem is not the manner in which this belief is presented—the belief itself is confusing and frightening.

I think almost everyone in our society has experienced aversive sexual abuse because of our unrealistic and negative attitudes toward children's sexuality. I will discuss the results of this aversive abuse in the next two chapters.

Sex therapist Helen Singer Kaplan imagines what childhood would be like if our society's attitudes about food were as negative as our attitudes about sex:

> What would happen to you if your mother's face reflected painful discomfort each time you took a bite of food; if you had to eat by yourself in the dark; if you were given the message that your mouth is repulsive; if you were not allowed to talk about food or admit you were hungry; if you heard sermons about the evil of eating and the sins of yearning for meat or sweets; if you could never share a meal with another person until you were in your mid-20s and married; if even fantasies about food were laden with guilt! It is safe to guess that in such a society stomach ulcers, appetite disturbances, bizarre oral desires, diarrhea, and constipation would be quite as common as sexual problems are today.[15]

Some individuals, for reasons not yet understood, seem to be able to overcome the shame of aversive abuse and establish satisfying sexual relationships as adults; perhaps as children they did not take adult warnings against sex too seriously. But other children are more sensitive to aversive abuse; as adults they may suffer from a wide range of sexual and emotional disorders: depression, anxiety, sexual aversion disorder (avoiding sex because it is experienced as unpleasant and anxiety provoking), premature ejaculation, impotence, inability to achieve orgasm, dissociation during sexual experiences, or paraphilia (the scientific term for perverted or "kinky" sexual desires).

There is abundant anecdotal evidence that sexual orthodoxy, whether Catholic, Protestant, or Jewish, is often associated with psychosexual pathology.[16] Masters and Johnson reported that 20 to 25 percent of the caseload at their sexual dysfunction clinic were couples who could not consummate their marriage.[17] After years of regarding sex as a sin, these couples had never learned to communicate sexually and to honor their sexuality. They did not regard sex as a natural function of being human; as a result, their sexuality did not function normally.

A sex therapy case study by Doctors William Simpson and Joanne Ramberg is a good example of how a sexually restrictive upbringing can cause sexual dysfunction and marital problems.[18] Here is my paraphrased summary of the case:

> Mr. and Mrs. Evans, a recently married couple, both 27, were referred to sex therapy because of the husband's severe erectile difficulties. A urologist had given Mr. Evans injections that produced erections, but he was unable to ejaculate when he and his wife had intercourse. Mrs. Evans said her husband did not seem interested in sex, although both had a strong desire for children.
>
> Mr. Evans had been raised by conservative Catholic parents who provided no sex education. He accepted the church's teaching that masturbation is a sin, so he did not learn to masturbate until he received instruction during sex therapy. Up to that point, Mr. Evans had never had an orgasm or a nocturnal emission. Mrs. Evans had been raised in a conservative Protestant family, but she was

> not as sexually inhibited. She had never masturbated, but she did have orgasms during intercourse with her husband after the injections.
>
> After practicing the classical behavioral techniques of Masters and Johnson for three months, Mr. Evans was finally able to get and maintain an erection when his wife stroked his penis, but he was still unable to ejaculate in her vagina through intercourse alone. He was not erotically excited by intercourse, feeling only wetness and warmth. He could ejaculate by masturbation, but it took a long time and intense stimulation.
>
> Mr. Evans interpreted his clumsiness with women as evidence of moral purity. This narcissistic pride strengthened his repression of his sexuality. His therapists encouraged him to take charge of his own sexuality, which had been managed in the past by his parents and priests.
>
> The sex therapy progressed to use of a vacuum pump to help Mr. Evans get erections, but he complained that he felt like a "piece of meat," despite the fact that Mrs. Evans had multiple orgasms after he used it. He was still unable to achieve orgasm in her vagina.
>
> After a year of sex therapy, Mr. Evans allowed himself to have erotic fantasies about an actress, and he was able to masturbate to orgasm more quickly. His erotic response was improving somewhat, but either he or his wife still had to masturbate him to the point of orgasm, then quickly insert his penis into her vagina. His therapists encouraged him to undergo psychoanalysis to understand his inhibitions and defense mechanisms, but he refused.

Even though Mr. Evans had some resistance to sex therapy, he deserves credit for sticking with it and for overcoming his inhibitions about masturbation. Learning to masturbate, or changing the way one masturbates, often plays a key role in sex therapy. Some sexually repressed individuals are unwilling or unable to overcome their inhibitions and drop out of therapy. There is very little that sex therapists can do for people who cannot let go of the guilt and shame they feel when masturbating.

Sexual deprivation can also result in sexual dysfunctions for women. It is now widely recognized that women who have never masturbated often have difficulty achieving orgasm. In their famous 1953 study of female sexuality, Alfred Kinsey and associates reported that if a woman has not had an orgasm by age 35, it is unlikely that she will ever have one. They pointed out that among women who had not experienced orgasm before marriage, 44% failed to have an orgasm during the first year of marriage. And they also compared devout Catholic married women with nominal, non-religious Catholic women, finding that 21% of the devout women had not had an orgasm by age 35, while only 2% of the non-religious women suffered from that dysfunction.[19]

Interpreting these findings, medical researcher K. E. Money has suggested that sexual deprivation may result in nerve degeneration in the walls of the vagina.[20] This hypothesis is consistent with the general principles of sensory and behavioral development. It has been proven repeatedly that sensory deprivation during the maturation period of a sensory system causes permanent neurological damage to that system, and normal responses to stimuli may never develop. This has been demonstrated for vision, hearing, touch, and other sensory systems. Sensory input, or lack of input, causes changes in the physical and chemical structure of the nervous system, and some of the changes are irreversible. Functional stimulation and activation are required for the development and maintenance of normal sensory neurons. Because of this requirement, an impoverished environment results in behavioral deficiency; behaviors that are basically

instinctive or reflex still need to be activated and practiced at the appropriate stage of development, or dysfunctions will result. The problems in sexual functioning associated with lack of masturbation are likely to have a biological basis.

Of course, sexual orthodoxy is never the only factor in the development of psychosexual problems. Kaplan observes that "most of those brought up in highly traditional and devout homes end up functioning more or less normally as adults."[21] William Masters and Virginia Johnson wrote, "There is as yet no explanation for why, of four siblings in a family completely devoted to religious orthodoxy, sexual dysfunction was found in two as they matured, but not in the other two (or perhaps in one or three out of the four)."[22]

Although Masters and Johnson could not identify vulnerable individuals by personality type, they could identify them by their interpretation of religious teachings and the way they personally internalized those teachings: "Those who internalize their religious orthodoxy in such a way that they interpret sex as sin, and/or sex as less than a natural function, and/or even more unfortunately, sex as dirty—these are the ones who later have difficulty with sexual responsiveness."[23] To put it more bluntly, the people who don't take orthodox sexual morality too seriously function normally, but the people who take orthodox morality very seriously are more likely to have psychological problems and sexual dysfunctions.

Kaplan has more specific ideas about which children are vulnerable to damage from religious orthodoxy:

> A child who has a low panic threshold and who may be handicapped by excessive separation anxiety is likely to be far more sensitive and responsive to parental censure. The malignant synergism between restrictive sexual training and the child's constitutional vulnerability is seen in the greater damage often apparent in these vulnerable individuals. His mother's objections to masturbation, even when they are mild and tempered with love, carry the intensely alarming threat of maternal rejection and abandonment. It may, therefore, be too risky for the anxious, phobic child to disobey and these vulnerable youngsters can develop especially intense and damaging masturbation guilt and avoidance.[24]

I once interviewed a man named Andrew who was the kind of child Kaplan described, and panic disorder was one of the primary symptoms of his sexual dysfunction. Here is Andrew's story:

> My mother was normally a mild-mannered and gentle woman. But she became angry when, as a small boy, I had to come into the bathroom to use the toilet while she was taking a bath. When I tried to look at her behind the shower curtain, she got so furious I was terrified. I experienced more of her terrifying rage on other occasions when she caught me with my pants down, "playing with myself" or simply exploring my body. I remember having an erection once as mom was drying me after my bath, and when she saw it, she angrily rubbed my genitals so hard with the towel that they hurt. I never saw my mother naked, and I didn't see my father naked until I was older.
>
> Mom doesn't remember any of these incidents, which doesn't surprise me. I'm sure she was acting unconsciously; she would never have deliberately acted cruelly. Like many Catholic women of her generation, she was programmed to be ashamed of her own sexuality and afraid of male sexuality. It's no surprise that my mother didn't know how to deal with my boyhood sexuality.

I'm sensitive by nature, and I became habitually withdrawn and fearful when I was only a few years old. I dissociated from my body and my feelings—life seemed to be an unending bad dream. I was completely ashamed of my body. I couldn't use public rest rooms, which caused a few classroom accidents in my younger years. I would never take my shirt off, even on hot summer days. Changing clothes in a locker room was mortifying—I was ashamed of my own body, and both fascinated and embarrassed by glimpses of other boys' bodies, which I didn't dare look at directly.

I enjoyed sitting on my parents' laps when I was little, but my parents were not very expressive physically or emotionally, and I don't remember getting much physical affection once I reached school age. Big boys don't cry, and they don't need to be hugged—but throughout my childhood, I often cried myself to sleep, wanting so much to be held and hugged, and ashamed of wanting it. I didn't doubt my parents' love—they were good to me, not overly critical, and gave me verbal encouragement (although we never said "I love you" until I was an adult). I had no close friends as a child, no one with whom I could share feelings or secrets or affection. I was afraid of everyone. I felt inferior and undeserving. I was depressed for my entire childhood.

My mother and father were both very uncomfortable talking about sex. I remember asking only one question about sex, when I was about 10, and their answer was so confusing and embarrassed that I never asked again. My father's "facts of life" lecture when I reached puberty was devoid of anatomical details and left me totally mystified about what a man and woman actually did during sexual intercourse.

Religion was my great consolation. Receiving Christ's body in Communion was proof that God loved me, even though I saw nothing lovable in myself. But instead of providing healthier attitudes toward sexuality, the church reinforced the fear, ignorance, and shame that were instilled by my family. The church said sexual thoughts and desires were impure and sinful—in fact, "impure" was the church's preferred synonym for the too-racy word "sexual." As for sexual activity—I'm sure many Catholics (and maybe a few Protestants) recall the sermon about the teenage boy and girl who engage in "impure actions" in a parked car, then on their way home die in a traffic accident and go straight to hell!

Puberty was especially difficult for me. I found myself increasingly fascinated by both male and female bodies, although my experience of both was very limited. I had no access to pictures of naked people except for a few art books and, of course, National Geographic. Because of my low self-esteem, my early sexual fantasies tended to be masochistic—I imagined groups of naked people stripping off my clothes, laughing at me, beating me, and pushing me naked into the mud. There was a strange power to those awful fantasies, but they filled me with confusion and shame.

My sex life was limited to masturbation, and even that was a problem. The church teaches that masturbation is "objectively" a serious sin against nature, because it does not lead to procreation. However, the church provides arguments for the defense as well as the prosecution—subjectively, the seriousness of the sin of masturbation is usually diminished because the will is weakened by habit, passion, or physical fatigue. The implications of this teaching, I now realize, are bizarre. In the "habit" defense, the church offers, in effect, a "frequent wanker discount"—the more often you do it, the lower the penalty. But as a teenager, I was too idealistic to take advantage of such bargains. I tried to avoid masturbation as much as possible, and when I couldn't resist, I waited until I was half asleep to minimize my responsibility and guilt.

When sexually tempted, I turned my thoughts toward God. By combining prolonged sexual arousal with spiritual openness, I was unknowingly practicing a form of tantric yoga. It led me to some extraordinary mystical experiences of loving union with God. But I had no teacher for such an advanced practice, and I was physically and psychologically unprepared for handling such powerful psychic energy.

At age 18, after a number of panic attacks, I had a nervous breakdown. The critical incident felt like a bolt of electricity traveling from the top of my head to the base of my spine. Much later I identified this experience as what Hindu yogis call "descending kundalini," but at the time, I had no idea what had happened. I thought I must be seriously ill, and wondered if I was dying. My anxiety spun out of control, and since I didn't know how to avoid hyperventilating, my father had to take me to the emergency room, where I was told to breathe into a paper bag and sent home. But I was physically disabled for a month. Making even the simplest movements to take care of my basic physical needs required an extraordinary effort of will.

Our family doctor found nothing wrong with me except elevated blood pressure, so he sent me to a neurologist for further testing. (Both doctors were devout Catholics.) The neurologist's tests showed nothing unusual except a high level of tactile sensitivity and a slightly abnormal EEG. The neurologist asked if I ever went on dates or to mixed parties. I said no, wondering what that had to do with my illness. He advised me to have more contact with girls, which made no sense to me at the time. He prescribed a heavy dose of Phenobarbital and Librium to control my terrifying panic attacks.

The drugs helped a little but did not make the panic attacks go away. For several weeks I wondered if I was going crazy. In retrospect, it's obvious that I should have been taken to a psychiatrist, but I don't remember anyone even mentioning that option. My parents and doctors didn't seem to know how to help me, and I certainly didn't know how to help myself. I felt hopeless and terrified. I thought about suicide, but didn't have the courage to seriously consider it. Hell could not feel worse than this, I thought. My only refuge was God's love and my belief that life was good, even though I had no evidence to support that belief at the time. I faced a choice—to give in to the illness, whatever it was, or to fight it. I chose to fight.

So, for the first time in my life, I had to learn to pay attention to my own body. By trial and error, I learned that conscious physical relaxation would relieve my panic attacks, and that massaging my genitals was one of the best ways to relax. I also learned how to unfocus my mind to disengage it from compulsive thoughts that fed the anxiety. After nine months, I gained enough control over my body and mind to stop taking the medication. The panic attacks continued for several years, but I finally knew they were harmless and I could take control of myself.

My experience was raising some interesting questions. If massaging my genitals was good for my health, how could it be sinful? And was I really so holy for obeying the church's rules about sex? The summer after my nervous breakdown, I worked on the staff of a Catholic boys camp, where I was first appalled, then fascinated, by the sexual behavior of the other teenage staff members. They were typical horny adolescent males who kept stacks of Playboy magazines under their beds, masturbated with gusto, loved talking about sex, and spent the summer nights trying to get into the panties of the teenage girls whose families' summer homes shared the lake shore with our camp. Serious sinners, according to Catholic teachings. But there was one problem—those "sinners" were more friendly, loving, and generous than I was, and isn't love the most important virtue? It didn't add up.

I also had a hard time picturing God as a torturer, giving people powerful sexual desires and forbidding their satisfaction. If we couldn't trust our own bodies, who or what could we trust? So I finally decided that the church's prohibition of masturbation didn't make any sense. At age 19, for the first time in my life, I masturbated in the daytime, fully awake and conscious, trusting my own body, my own perceptions, and my own judgment. I had never seen myself ejaculate before. My whole being told me that it was good. That afternoon was the beginning of my sexual healing. I still had a long way to go, but I had decisively taken charge of my own life.

Even though I was no longer afraid of masturbation, I was still afraid of sex. I had no idea how to initiate a relationship of any kind, much less a sexual relationship. In my early twenties, I realized I was gay, but I was afraid of associating with gay men. I didn't have sex until I was 31. My sexual

> self-esteem was so low that I was amazed that any man would find me attractive. I ended up living with Bert for ten years. We were both sexually inexperienced and emotionally inhibited. We had a good time at first, but we never had any emotional intimacy outside of sex, and I needed that, so eventually we broke up.
>
> In my forties, I finally entered adolescence—I began actively dating. I also joined a men's support group and for the first time was allowed to enjoy physical affection with other males. I began taking workshops on sexuality, intimacy, and erotic spirituality. As I made progress in healing the shame that was imposed on me as a boy, I started the sexual exploration and experimentation that I had missed as a child. I learned a lot about physical intimacy—how to touch in a loving and respectful way, how I like to be touched, how to ask for what I want, how to have erotic fun safely. Recovering from childhood abuse has taken me a long time, but it's been worth the pain and effort. I've finally found a lover who enjoys emotional intimacy as much as I do.[25]

Negligent Sexual Abuse

I define negligent sexual abuse as failure to give children accurate and adequate information and moral instruction about sexuality at appropriate ages; failure of parents to model healthy attitudes toward sex, love, intimacy, and physical pleasure; and failure to give children emotional empathy and physical affection.

Sex education is one of the ongoing responsibilities of parenting. The rule of thumb for sex education is that every question a child raises, at any age, deserves an accurate and honest answer. Children who are deprived of information about sexuality will either make up their own answers or turn to their peers for information, often perpetuating errors and misperceptions. Inadequate sex education makes children more vulnerable to sexual abuse, unwanted pregnancies, and sexually transmitted diseases. The idea that sex education promotes premature or increased sexual activity is a superstition that has been refuted by dozens of scientific studies and repudiated by the World Health Organization.[26]

Sex education must also include moral education. What children need to hear is not that all of their sexual activities are wrong or sinful, but that sexual activities must always be consensual. Parents also need to model healthy personal boundaries and not violate their children's boundaries. I will discuss sexual ethics in more detail in Chapter 10.

Parents who feel uncomfortable talking about sex have a moral obligation to raise their comfort level, because children stop talking about sex when they sense their parents' discomfort. I suspect that the communication gap between parents and children, which so many people assume is inevitable, is simply the result of children knowing that they can't talk with their parents about sex. Once this important part of life is declared off limits, other important areas of life seem to follow. On the other hand, parents who are comfortable talking about sex seem to have more open communication with their children about every aspect of their lives.

Parents are the models for children's emotional and sexual development. Parents' healthy attitudes about their bodies, pleasure, intimacy, and sexuality will be absorbed by their children. If the parents have neurotic attitudes, the children will either mimic them or react against them in immature ways. As we will see in Chapter 6, a child's first intimate and erotic bond is (or at least

should be) with his or her parents, and a healthy parent-child bond is the foundation for emotional and sexual development.

In our discussion of sex offenders in the last chapter, we saw the potentially disastrous consequences of failing to bond with one's parents and then following the "attack other" strategy. The following case study of a man named Brian illustrates a bonding failure combined with a different reaction—the avoidance strategy—manifested in an addiction to sex with prostitutes. This case combines negligent sexual abuse with multiple forms of physical and emotional abuse:

> I was raised in a strict Irish Catholic family. Sex was a forbidden topic in our family, and I got no sex education from my parents. (I recently learned that my mother, as a girl, was sexually molested by my grandfather.) No one in our family had any physical contact. Hugging and kissing were alien concepts. Once, when I was eight years old, my father was standing on a ladder and I noticed the hair on his leg. I reached up to feel it, and he exploded in anger, screaming, "Don't ever touch me!"
>
> I was a star pupil in Catholic school, smart and well-behaved, but I still suffered plenty of humiliation. One frequent source of embarrassment was the nuns coming into the boys' restroom and watching us urinate—supposedly to keep us from urinating on the floor or otherwise misbehaving. We had to huddle together to keep the nuns from seeing our penises.
>
> A crisis occurred in the seventh grade, when a nun was haranguing and shaming our class (I don't remember the reason). I got fed up and defied her by getting up to use the pencil sharpener without permission. The sister made me stand in a wastepaper basket for the rest of the day, as if I were human garbage. The next day she made me apologize in front of the class. I was humiliated and reduced to tears. I just stood in front of the class, sobbing. I got no consolation at home; my parents always supported the nuns.
>
> After crying in front of the class, I became a social outcast. My friends abandoned me. My classmates would not invite me to share in any activities. No one trusted me, either girls or boys. In social situations my stomach tightened and I had breathing problems. I became the class clown to cover up my shame, but my self-esteem was destroyed.
>
> Although I was not usually assertive with girls, one day in the tenth grade I touched a pretty girl's hair. Unfortunately, the nun saw me do it. She took me out of the classroom, lifted me off the ground by my throat, banged my head against the wall until I was unconscious, and left me on the hallway floor. When I regained consciousness and went back into the classroom, the nun and I both pretended that nothing had happened. I was too terrified and ashamed to tell anyone about the incident.
>
> By the eleventh grade, I had had enough. I left Catholic school and the church. After graduating from public high school, I paid my own way to attend a state college, because my family would only pay for a Catholic college. I made sure that none of my new friends were Catholics. But it took me a long time to recover from my poor self-image and lack of self-identity. For years I lived primarily in my fantasies. I worked at several jobs, but did not settle into a career until age 35.
>
> I felt so vulnerable around women, I thought I had to take anyone I could get. Eventually I married an incest survivor who, like my mother, had been molested by her father. My wife had serious sexual inhibitions. She couldn't stand being touched on several parts of her body—she was like a checkerboard, and I could only touch half the squares. Even so, after six months of marriage she started having affairs. I later learned that she also masturbated compulsively. When she started her affairs, I started going to prostitutes for sexual satisfaction, and I liked it better than sex with my wife because there was no emotional involvement.

> I became addicted to prostitutes and eventually divorced my wife. For 20 years, I had sex with prostitutes four or five times a week, on average. During binges, I would spend all night on the street, having sex with four or five hookers in one night. A lot of my disposable income was wasted on this addiction. At age 33, I had a breakdown and spent two years in therapy, but I never mentioned my sexual addiction to my therapist.
>
> My life finally took a positive turn when, in my 40s, I started taking personal growth classes and workshops. Men-only workshops made the biggest difference by helping me recover my authentic male identity. I was finally able to tell the truth about my addiction to prostitutes. For the first time, I began to develop meaningful relationships, which helped me overcome my sexual compulsion. The [Human Awareness Institute's] Intimacy, Love and Sexuality Workshops helped me develop a positive, healthy attitude toward sex. And after 25 years as an agnostic—I couldn't understand how God could let such awful things happen to me—I became religious again.[27]

Lovemap Development and Paraphilia

As we will see in Chapter 6, children seem to have a biologically built-in schedule for learning about sex through experience. Their sexual development can be harmed by attempts to speed up or slow down their sexual experience. The medical sexologist John Money coined the term *lovemap* to describe each person's mental image of the ideal lover and what kind of sexual and romantic activities they will enjoy together.[28] Money's clinical experience led him to hypothesize that lovemaps are established for life usually between the ages of five and eight, although this needs to be confirmed by further research. The hormones of puberty may put sexuality into high gear, but the direction in which that sexuality will develop is often determined earlier in life. Sexual play with children of the same age and developmental stage seems to facilitate the development of a normal lovemap. Sexual activity between children and adults is harmful because it speeds up sexual experience in ways that overwhelm the child. On the other hand, preventing or punishing masturbation or sexual rehearsal play with peers is also harmful because attempts to slow down the child's sexual development may arrest or distort that development.

Paraphilia, one possible outcome of a disturbance in lovemap development, is a disorder of pair-bonding that involves dependence on an unusual and personally or socially unacceptable stimulus for erotic arousal and orgasm. Most patients with paraphilias described a strict anti-sexual upbringing in which sex was either never mentioned or was actively repressed or defiled.

The type of paraphilia that develops seems to be a matter of chance, depending on random circumstances. Deprived of the opportunity to bond erotically with another child, the paraphilia sufferer bonds with objects or activities that are given erotic meanings. Well-known paraphilias include voyeurism, exhibitionism, fetishism, bestiality, sadism, masochism, and pedophilia. Less well-known paraphilias include ephebophilia (attraction to teenagers), rapism (arousal to rape), frotteurism (rubbing against strangers), infantophilia (infants), somnophilia (sleeping strangers), necrophilia (corpses), apotemnophilia (self-amputation), asphyxiophilia (self-strangulation), erotophonophilia (lust murder), and many others.

To understand the origins of paraphilias, it's useful to compare lovemap development to language development. Children are biologically programmed to learn language during the first seven years of life. They will learn whatever language they are exposed to; and although some will learn other languages later in life, they will rarely unlearn their first language. Children who are kept in isolation and not exposed to any language by age 7 may later be taught the meanings of words, but they will never be able to speak normally in complete sentences, because they missed the opportunity to learn language during the appropriate stage of brain development. Two children kept in isolation together may develop their own language, incomprehensible to anyone else.

Lovemaps are the languages of sexual and romantic communication. Between the ages of 5 and 8, if children learn the basic facts of sex and have opportunities to play at emotional bonding and physical intimacy with each other, they will usually develop normal lovemaps; that is, they will learn ways of communicating erotic attraction and emotional bonding through shared physical pleasure. If adults prevent or punish this kind of experiential learning through aversive or negligent abuse, the children may develop distorted lovemaps or paraphilias.

John Money's book *Lovemaps* is filled with case studies of childhood sexual development gone awry, and I will summarize two of them here. The first is the case of an acrotomophile, a man sexually attracted to amputee women. Money does not give the man a name, but for convenience I will call him David.

> David was raised by his religious grandmother and mother with no male role model in the home. The two women constantly criticized men and denigrated masculinity, and any normal boyish behavior of David's was criticized and punished. His mother and grandmother defined a "nice boy" as someone who didn't act like a boy—who was not assertive and competitive, who did not go roaming and exploring, who did not play sports, who did not stand up for himself and fight, who did not play to win. If David dared to assert himself, he was beaten with a tree branch on his bare buttocks. David's masculine identity was constantly under attack.
>
> Not only did David's family forbid sexual relationships, they even made normal friendships impossible by forcing the boy to stay in his own yard. Normal sexuality is difficult to achieve without a normal social life. And because the boy was not exposed to a variety of values in the families of friends, he had no inspiration to rebel against his family's strict controls.
>
> At puberty, David's attraction to girls produced strong feelings of guilt. But by chance he had heard a story about the courage and strength of a young girl amputee, and he thought that he might be allowed to be attracted to a girl if she were an amputee. He used this fantasy to assuage his sexual guilt and to avoid contact with real girls, since he didn't know any amputees. He began to actively seek out stories of female amputees, whom he idolized, and they became the focus of his sexual fantasies.
>
> But David's erotic strategy was self-defeating. As an adult, when he finally mustered enough courage and strength to meet real women amputees, and saw them as real people instead of idealized images, his erotic attraction evaporated.[29]

Money also relates the case of a boy who developed multiple paraphilias—in addition to being a pedophile, he was sexually homicidal and suicidal. Here, in my words, is an abbreviated version of his story:

> At the age of 19, a quiet, religious young man named Frank was arrested for making threatening phone calls to a neighbor who had a 6-year-old son named Calvin. Frank's phone threat was, "I want to kidnap your kid and I want to kill." He was sent to a psychiatric hospital for evaluation and was later interviewed by a sexologist, who uncovered some relevant facts about Frank's childhood.
>
> As a child, Frank had learned nothing about sexuality from his parents or his peers. On one occasion when he was 6, his parents beat him as a punishment for masturbating in the bathtub. He continued masturbating, and three times his parents interrupted his bath to beat him. This incident seems to have arrested Frank's psychosexual development at age 6.
>
> In his early teens, Frank developed multiple personalities. His second personality was a 6-year-old named Joey who never grew older. Joey fantasized about being kidnapped, murdered, and resurrected as a better person. At first this fantasy was not sexual. Sometimes Frank would have an erection when he saw young boys and thought about touching them, but he didn't understand his reaction. "It was sexual," he said, "but I didn't know it was sexual. I didn't know what it was."
>
> Frank went through a long period of obsession with religion, making up long lists of rules and obligations, and eventually working up to 500 prayers a week. Around age 18, Frank's religious obsession was replaced by Joey's fantasies of kidnapping or being kidnapped, killing or being killed. These ideas now became masturbation fantasies. To kill Joey and fulfill his fantasy, Frank attempted suicide three times. Then he began carrying out his sex murder fantasy with pictures, painting wounds and blood over pictures of young boys, including Calvin, then masturbating. Sometimes the pictures would represent the boys themselves; other times they would represent Joey.
>
> When the bloody pictures grew sexually unsatisfying, Frank, as Joey, began sending letters and making phone calls to Calvin's parents. Frank described his fantasy: "My desire was to kill myself and kill Calvin, and somehow be born as Calvin. I don't know how that would have worked out. I wanted not only to be Calvin; but [his parents] Jeff and Kay seemed like such good parents toward Calvin that I would have loved to fall into their hands. I wanted them as my parents.… I wanted to be Calvin, but deep down inside, I didn't really want to hurt the boy. So I started sending letters, threatening letters, and I started making phone calls.… I said I was going to kidnap Calvin, and I was going to kill him.… What I wanted all along was … to be arrested and go to jail … and I wanted to kill myself." [30]

There is a symbolic logic to Frank's paraphilias. Masturbation, a child's first sexual activity, represents all sexual pleasure; to be punished for masturbation is to be punished for being sexual. At age 6, Frank's sexual development was arrested when the idea that sex is evil was beaten into him. Because a good, religious person could not be sexual, Frank split off his sexuality into a separate personality, Joey, who remained 6 years old and could only be attracted to other 6-year-olds. Frank's religious training provided the idea of death and resurrection as atonement for sin. Because Joey was sexual, he had to be murdered and resurrected to atone for his sins. Frank's three attempts to kill himself (and murder Joey) echo the three beatings he received for masturbating. The boys Joey was attracted to also had to be murdered in fantasy for arousing his sinful desires. When the fantasy atonement was completed, Frank could achieve orgasm. It was fortunate for Calvin and other neighbor boys that Frank gave warnings before he started acting out his fantasies; many sex murderers give no warning.

Non-Contact Sexual Abuse and Sex Offenders

It's now time to look at how the things we have learned about shame, aversive and negligent sexual abuse, and paraphilias apply to sex offenders.

Because the opposite of self-esteem is shame, and we already know that sex offenders have low self-esteem, we can infer that they have high levels of shame. Given psychologists' long neglect of shame, it's not surprising that only recently has shame been identified as a core issue for sex offenders.[31] Much more research needs to be done on this issue, but we can say with confidence that a high level of interpersonal and sexual shame is consistent with everything we know so far about sex offenders.

One of the few explicit findings so far on the aversive abuse of sex offenders comes from the study *Pornography and Sexual Deviance* by Goldstein, Kant, and Hartman.[32] Comparing rapists with non-offenders, these researchers found that as children, 100% of the future rapists whose parents caught them looking at pornography were punished, while only 7% of the control group were punished for looking at pornography. Many of the non-offenders' parents discussed with the children what the pornography showed, but none of the rapists' parents took this empathetic and educational approach.

Parents who punish children for their sexual interests and activities are actually modeling sexual abuse. By their actions, these parents are teaching their children disregard for another person's bodily autonomy and emotional and sexual feelings; they are teaching that aggression, humiliation, and violation of personal boundaries are the rights of people with power. More research needs to be done on how parents and caregivers responded to the sexual behaviors of children who grew up to be sex offenders. I predict such studies would show that almost all, if not all, of the offenders have suffered some form of aversive sexual abuse, which produces unbearable shame, which in turn, as we have seen, can lead to attacks against others.

An interesting fact that such research might explain is that some sex offenders do not have a general lack of empathy, but only lack empathy for their victims.[33] Perhaps these offenders grew up in a somewhat healthier emotional environment than other offenders, but were punished for their sexual activities, teaching them to not have empathy around sexuality.

The connection between negligent sexual abuse and sex offenders is already well established, although not using my terminology. We know that most sex offenders had inadequate sex education, and that virtually all of them came from families lacking in affection and emotional communication. Paraphilias are also widely acknowledged as motivating some offenders, although the origins of paraphilias need to be researched more thoroughly.

What I have tried to show in this chapter is that in America, sexual abuse is a traditional family value. The suppression and shaming of children's sexuality—a defining characteristic of our traditional culture—makes a direct contribution to sexual aggression. In the next chapter I will show that the shaming of children's sexuality also creates an atmosphere of tolerance for sexual

abuse by promoting a culture of sexual secrecy, denial, and dishonesty, in which sexual abuse can flourish.

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[1]Nathanson 1992: 460.

[2] Robert Karen, "Shame," The Atlantic Monthly, February 1992, p. 43.

[3] Helen Block Lewis, *Shame and Guilt in Neurosis.*

[4] Karen, p. 40.

[5] Karen, p. 55.

[6] John Bradshaw, *Bradshaw On: The Family* (Deerfield Beach, Florida: Health Communications, Inc., 1988), p. 114.

[7]Nathanson, 28.

[8]Nathanson, 49.

[9] Silvan S. Tomkins, *Affect/Imagery/Consciousness, Vol. 2: The Negative Affects* (New York: Springer, 1963), p. 118.

[10]Nathanson, 73.

[11] Nathanson, p. 143.

[12]Nathanson, 86–87.

[13] Ibid., pp. 305–377.

[14]Jacoby 1994: 46.

[15]Helen Singer Kaplan, *Making Sense of Sex: The New Facts About Sex and Love for Young People* (New York: Simon & Schuster, 1979).

[16]Kaplan 1987; Patton 1988; Shea 1992.

[17]Masters and Johnson 1974.

[18]Simpson and Ramberg 1992:518–520.

[19]Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, and Paul H. Gebhard, *Sexual Behavior in the Human Female* (Philadelphia: W. B. Saunders Co., 1953).

[20] K. E. Money, "Physical Damage Caused by Sexual Deprivation in Girls," Medical Hypotheses 4: 141–148 (1978).

[21]Kaplan 1987:52.

[22]Masters and Johnson 1974:89.

[23]Ibid.

[24]Kaplan 1987:52.

[25]Personal communication.

[26] "Sex Education Classes Don't Lead to Sex," San Francisco Chronicle, December 18, 1993.

[27]Personal communication.

[28]John Money, *Lovemaps: Clinical Concepts of Sexual/Erotic Health and Pathology, Paraphilia, and Gender Transposition in Childhood, Adolescence, and Maturity* (New York: Irvington Publishers, 1986).

[29] Adapted from Money, *Lovemaps,* pp. 215–226.

[30]Adapted from Money, *Lovemaps,* pp. 127–130.

[31] Susan D. Romanczuk, "The Identification of Shame As a Core Issue for the Adolescent Sexual Offender," Dissertation Abstracts International Section A: Humanities & Social Sciences 61: 2469 (2000).

[32] M. J. Goldstein, H. S. Kant, and J. J. Hartman, *Pornography and Sexual Deviance* (Los Angeles: University of California Press, 1973).

[33] James H. Geer, Laura A. Estupinan, and Gina M. Manguno-Mire, "Empathy, Social Skills, and Other Relevant Cognitive Processes in Rapists and Child Molesters," Aggression and Violent Behavior 5(1): 99–126 (2000).