Journal of Cognitive and Behavioral Psychotherapies,
Vol. 12, No. 2, September 2012, 231-239.

SEXUAL ABUSE AND MASOCHISM IN WOMEN: ETIOLOGY AND TREATMENT

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Abstract

A common manifestation and pattern of sexual masochism was observed in several female clients in psychotherapy. Three female clients who had all been sexually abused by a parent commencing in preadolescence are presented. All of these women demonstrate a consistent pattern of arousal from pain and humiliation inflicted during sexual encounters. An explanatory model of the origin of this paraphilia in women is presented. This model integrates Daryl Bem's EBE model of sexual preference with the theories of John Money. In effect, it is proposed that masochism is an adaptive response to abuse, wherein the rage and shame become integral to sexual arousal. Additional links between abuse and the etiology of masochism are explored and the outcome of treatment with Rational-Emotive and Cognitive Behavior Therapy (RE&CBT) is presented.

Keywords: sexual masochism, borderline personality disorder, Rational-Emotive and Cognitive Behavior Therapy

Sexual masochism, like most paraphilias, interferes with achieving meaningful sexual relationships. Masochism is a particularly vexing paraphilia, in that stimuli that are nearly universally aversive become sources of sexual delight. Humiliation, ridicule, subjugation, and pain become triggers for sexual excitement. According to Kinsey, Pomeroy, Martin, and Gebhard (1953), 22% of American men and 12% of American women acknowledged being sexually aroused by depictions of sadomasochism. Donnelly and Fraser (1998) found that 61% of college students acknowledged being aroused by fantasizing about or performing sado-masochistic acts.

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Theories of Masochistic Sexuality

Theories regarding the origin of sexual masochism are abundant, as well as strikingly inconsistent with each other. Freud contended that masochism is an inherent aspect of feminine sexuality. This has been the focus of considerable criticism (Symonds, 1979); evidence shows that more men than women are aroused by masochistic fantasies or engaging in either being bound or being dominated during sex (Donnelly & Fraser, 1998).

Most sexual disorders and paraphilias are explained by psychoanalytic theorists in terms of trauma, deprivation, or excess during the late anal stage and the phallic stages of psychosexual development, during which Oedipal conflicts occur. However, the Oedipally-related theories can be questioned for good reasons as, over the past half century, there is virtually no support that an Oedipal conflict in development exists.

Of the non-Oedipal explanations of masochism, Van der Kolk (1989) proposed that traumatized persons are prone to respond to new events as though reliving the traumatic event. This unconsciously makes the current event stressful without any apparent reason. Van der Kolk (1989) proposes that abused or traumatized persons seek familiar, if painful behaviors to reduce the chronic arousal and anxiety caused by novel situations. Other less intricate theories include the proposal that masochism is the result of unresolved fears of separation or abandonment (Lego, 1992), of chronically seeing oneself as a victim (Warren, 1985), or of something as simple as a behaviorally reinforced response (Brown, 1965). Finally, Stoller (1975) posits that masochism and other sexual disorders results from early life passiveness in the face of maternal humiliation.

Alternatively, Daryl Bem's "Exotic Becomes Erotic" or EBE model of homosexuality (Bem, 2001; Bem, 1996) dovetails cogently with what might be the most evidence-based theory of masochism, set forth by noted sex researcher John Money (Money & Lamacz, 1989; Money, Annecillo, & Lobato, 1990; Money, 1991). Money formulated the concept of a "lovemap" that refers to a cognitive representation of the erotic ideal and sexual union with that ideal. In the case of a heterosexual man, the lovemap would contain the representation of a maximally attractive woman and a representation of intercourse with this ideal lover (Money, 1988). In the case of paraphilias, Money (1988), Money and Lamacz (1989) proposed that perturbing events during two key developmental phases can create a lovemap of sexual symbols. So, rather than being aroused by another person, the paraphile is aroused by some aspect, sometimes extraneous, of a person.

While Bem's and Money's theories seem to explain paraphilic masochism in males, they do a lesser job in the case of females. According to Bem's EBE (Bem, 1996; Bem, 2001; Nicolosi & Byrd, 2002), it is the salient aspects of the female, especially her secondary sexual characteristics that become

the triggers of male arousal. However, since females are not essentially visually aroused, their process of learning arousal cues, including masochistic ones is different. In short, male sexuality is predicated upon learning how to be appropriately aroused and female sexuality is predicated upon learning to select the appropriate aroused male. It follows that the gender difference in the development of arousal is the basis for the marked difference in the prevalence in paraphilias in men and women. Among the latter, a paraphilia like masochism would require far greater or prolonged disturbance during the development of sexual identity.

Clinical Cases

In support of the hypothesis that prolonged emotional, sexual, or physical abuse can be a causal factor in the development of sexual masochism, we present three case studies of women treated by the first author (their identities are disguised). In addition to their masochism, all suffered, to varying degrees, from borderline personality disorder (BPD), as well as depression or anxiety disorders. BPD is a particularly refractory condition, one in which the therapist's skills and patience will be continually challenged and tested. This disorder should invoke a great deal of caution in the treating therapist.

All were treated with Rational Emotive Behavior Therapy (REBT) which is concordant with the critical elements of Dialectical Behavior Therapy (Dryden, 2005), and which has been shown to be efficacious in treating BPD (Ellis, 1994) and sexual disorders (Ellis, 1971a, 1971b).

Case 1. Sharon O.

Sharon joined a therapy group lead by one of the authors for the purpose of weight loss. She stated that she wanted to make herself more attractive for her long-term boyfriend Bill. The group became enthralled by her success with weight loss and her self-effacing wit. Strangely, Sharon responded by disparaging the other group members, attacking them in response to their compliments and praise. Eventually she switched to individual therapy, explaining that the group was "driving her crazy". She described feeling severe mood swings including rage and anxiety. Sharon in individual therapy was a radically different person than the façade she had presented in group. She would avoid eye contact and would often seem to withdraw into herself. She was typically meek, with punctuations of rage or anguished tearfulness. Just as her demeanor changed, so too did her story. She revealed that her putative lover Bill was actually a closeted gay man who used her as an escort when he needed a "cover up". He would often ridicule her love for him and would periodically cease all contact with her when he would find a new male lover. Despite all of

his abuse and disdain, Sharon would always welcome him back into her life. She reported multiple suicide attempts, usually dramatic and superficial ones.

Sharon only had voluntary sexual intercourse once in her adult life; it was with a gay friend who would ridicule her for being fat. She had been raped three times, and she never reported the rapes to the police believing she had provoked them. One of her habits was to meet drunken men at bars and invite them home. Once the man was nude in her apartment, she would gleefully ridicule the size of his penis, and reject him. On several occasions this led to violent assaults by the ridiculed man. Sharon reports that she welcomed these attacks, as they instantiated her sexual fantasies of being raped and murdered. Sharon explained that humiliating men – sadism - did not arouse her sexually; it simply made her feel good. In contrast, placing herself in harm's way, which facilitated her rape and victimization fantasies, did arouse her.

Only after an extended period of tumultuous psychotherapy did Sharon first talk of her victimization by her father. He was a hostile alcoholic who was bitter about his failings in life. He would often force her into sexual acts. Before the age of 11 these would be limited to fellatio, manual stimulation, and fondling. When Sharon was a bit older her father began raping her. While raping her, he would exhort her to thrust and act as though she enjoyed it. The sexual assaults ended after Sharon attempted to flee home at age 16. Her father continued to vigorously disparage and ridicule her until she left home at age 20. Sharon's therapy was Rational Emotive Behavior Therapy that set out initially to offset many of the secondary problems of sexual and other life problems (Ellis, 1971a; Ellis, 1975). During therapy, the masochistic tendencies were replaced by more adaptive and conscious ways of behaving. In therapy, she was afforded unconditional acceptance as a person. Sharon's guilt and shame about her sexual history and behavior was addressed by helping her understand that her foibles were the direct result of a life history that was not her fault. The therapeutic relationship was very much predicated on the therapist being extremely stable, consistent, and available. This was to challenge her conviction that she could never be treated well or have a stable relationship. In fostering unconditional self-acceptance, the treatment followed one of the core principles of REBT, that the value of a human being is unconditioned, regardless of particular life experiences and behaviors (Ellis, 1994b). She eventually was able to garner a vastly improved degree of emotional control. Sharon was also helped with practical problems. This included encouraging her to seek female friends and to minimize the relationships with her gay friends which only reinforced her negative self-image. The years brought radical changes in her self-image, emotional stability, and behavior. Sharon was finally able to maintain stable friendships with women. She still had difficulty with men, but had succeeded in a couple of dates. Notably, her self harm, parasuicidal acts, and desire for masochistic sexual acts had markedly diminished.

Case 2. Arlene

Arlene sought help for being unhappy and anxious. She spoke in a slow labored manner and suffered from mild strabismus. She would reveal that she suffered from a range of neurological problems that included dyslexia, memory impairments, and bouts of syncope. A physician told her parents that her mental functioning might be too low for her to live independently. Despite this prediction, her handicaps and a third grade reading level, she nevertheless graduated high school, married a prominent individual, and raised two daughters. Early in therapy Arlene would complain about vague physical symptoms and a range of dysphoric psychological states. In addition, she expressed severe borderline symptoms that included a labile mood and a tendency to complain about and disparage everyone in her life. In fact, Arlene perceived virtually every figure in her life as an untrustworthy foe. After several months of care Arlene developed trust in the therapeutic process, requested twice weekly sessions, and finally, she confessed about her sexual abuse by her father. The father's sexual abuse began with fondling and forced fellatio and escalated to frequent rape. She reported that she first felt the behavior was merely strange and uncomfortable, as she did not understand what he was doing. Over the years she became fully aware of her role in her father's life. Her father responded to Arlene's expressions of distress with increased cruelty by mocking and ridiculing all of her daily efforts. Her father, like most of those of abused clients, seemed to assuage his guilt by diminishing the worth of the victim.

Arlene told of becoming very sexually active in her mid-teens, consistently selecting men who would abuse or degrade her. Notably, she indicated that she was fully aware that they thought they were taking advantage of her, and she acknowledged that this enhanced her arousal. As she grew older her arousal at being degraded and sexually humiliated increased. In addition to seeking abuse by others, she would, when feeling disrespected by significant people in her life, gash her thighs and buttocks with sharp objects, usually with a serrated knife. In therapy, she was alerted to potentially self-defeating behaviors. These included emotional outbursts with family, sexually promiscuous behavior, and excessive crying or complaining. Arlene was gradually helped to understand that her emotions were a result of her beliefs about the world. She was helped to challenge her demand that her family understand and accommodate her problems. In addition she was helped to better express the logic behind her rage at her father and the others that seemed to follow his legacy in ridiculing her; she came to see that she had engaged in a vicious circle of seeking abuse only to feel shamed and degraded thereby increasing her need to be abused. She was helped to think differently about these people and make them less relevant with her day to day life. She was helped with social skills in order to make some new friends, on more positive terms.

Case 3. Barbara

Barbara commenced therapy with speaking about difficulties with her college professional training program and some problems in her relationship with her boyfriend. At the end of the session though, Barbara confessed to drinking some antifreeze.

The therapist brought her to the hospital where she was hospitalized for a week of treatment to detoxify the propylene glycol. Remarkably, she received no psychiatric care, as she was able to convince the psychiatric resident that it was an accidental consumption. Over the next three years Barbara would come for therapy 3 times a week. It took several months of therapy for the psychologist to fully apprehend Barbara's situation, history, and pathology. She had been hospitalized twice before, been home tutored as a result of behavioral and psychiatric pathology and spent three years in a secondary school for teens with psychiatric or behavioral problems. She suffered from extreme social phobia, anxiety, and profound BPD. The psychologist, as with all such clients, made all possible efforts to maintain therapeutic equanimity. This was often difficult as Barbara made every effort to provoke him. With time, her attachment to the therapist, as well as her hostile personal attacks increased. She stole items from his office, perpetrated minor vandalism, and would make sexual offers and threats via email. Frequently she would describe herself as a "calculating psychopath" and would inform the psychologists that he and his family were in danger from her. However, it was clear to the psychologist that she was a victim, not a victimizer. Barbara still lived with her parents. Without friends (the boyfriend she spoke of in the first session left her after a month), her only social contacts consisted of brief sexual encounters with men. These were often men whom she saw as undesirable or dangerous. They were always somewhat demeaning to her. Barbara insisted that she could only enjoy sex if she was hurt or debased. Besides her sexual liaisons, most of her time was spent sitting in her car without heat or cooling, so she would freeze in winter and simmer in the summer. The more suffering the better as she was convinced she deserved it.

Barbara eventually revealed that her father began sexually abusing her at the age of eight. He would share pornography with her before raping her. He would demean both Barbara and her mother and imply that it was either Barbara's or her mother's fault that he was doing this. Despite the sadistic and pathological nature of her father's sexual assaults, she had grown to become aroused by them. The humiliation in sex now produced intense arousal. This left her feeling either like an accomplice or provocateur in the relationship with her father, along with an urge to re-create that relationship with the men she would pick up later, as an adult woman.

Treating Barbara presented acute difficulties as her personality disturbances produced radical differences in her behavior from session to session. Barbara was painfully aware of this and stating that she "had no person inside of

me". Her REBT targeted the reactions to these identity problems and the anger and self-hate they would engender. As with the other women presented in this paper, Barbara was helped by the stability of the therapeutic relationship that tacitly challenged the belief that "I am completely worthless, and have no identity." Barbara's response to most REBT interventions was anger or grief and a consequent attack on the psychologist; this would be countered with equanimity and patience. Her failure to produce the anger and hate she felt she deserved provided some persuasion that she was not a "bad "person." Just as with the other women presented here, Barbara was provided both frequent email and telephone contact.

Masochism and Abuse

Based on these representative cases, sexual masochism in women is likely to require severe or prolonged trauma. In the presented cases, there was a tendency for the sadomasochistic paraphilia to intensify with time. This seems to be the case for most paraphilias, that is, they are refractory to treatment and often seem to acquire an obsessive quality over time. The reason is that the general arousal theme becomes fixed in early development but the specific target does not. Thus, if a person develops a sexual theme around degradation, that theme is fixed, but the specific method of degradation is not. The specific means to degradation is subject to habituation, consequently requiring greater acts of degradation to achieve arousal. All of the women presented suffered severe emotional trauma during key developmental times. This seems to be requisite for women to develop sexual masochism (and perhaps other paraphilias). Prolonged feelings or rage, fear, and helplessness appear to be required. All of the individuals presented also suffered from some degree of BPD, which raises the possibility that this disorder may be a causal factor in masochism rather than a simultaneous consequence of the same noxious events.

Treatment

Historically, the mainstay treatment of paraphilias has been psychoanalytic. Most treatments of male paraphiles have had, at best, modest success (Krueger & Kaplan, 2002; Kilmann, 1982). We propose a slightly more optimistic view of treatment for persons who develop masochism as a result of abuse. The moderate success we have observed in our clients was the result of rational emotive / cognitive behavioral therapies that conveyed the afflicted a new, stable relationship with the therapist. Although maintaining boundaries with such clients is difficult, it can be done, while still demonstrating a firm commitment to help with regular contact, unconditional acceptance, strong resistance to personal attacks, and a persistent assault on the clients' irrational beliefs predicated on their worthlessness.

Conclusion and Future Research

This paper is the result of observing some common factors among masochistic women who had suffered early life trauma. Specifically, we observed that people suffering shame or rage during adolescence tend to become masochistic. This phenomenon seems to be particularly reliable in women, who rarely develop other paraphilias. It was our inference that sexual masochism is as adaptation of the sexual orientation process by which the trauma becomes the moving force of the individual's sexuality. Female masochists, in contrast to their male counterparts, appear to have their sexual motivation as result of prolonged and severe trauma, which also incites borderline personality, rage, and sadistic fantasies. We have obtained reasonable success with the use Rational Emotive / Cognitive Behavioral therapy. This approach seems to be effective for those afflicted so long as it combined extraordinary therapist equanimity and consistency. None of the individuals had their paraphilias eliminated, but all achieved some degree of control over them, and a reduction in their guilt and shame over having them.

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