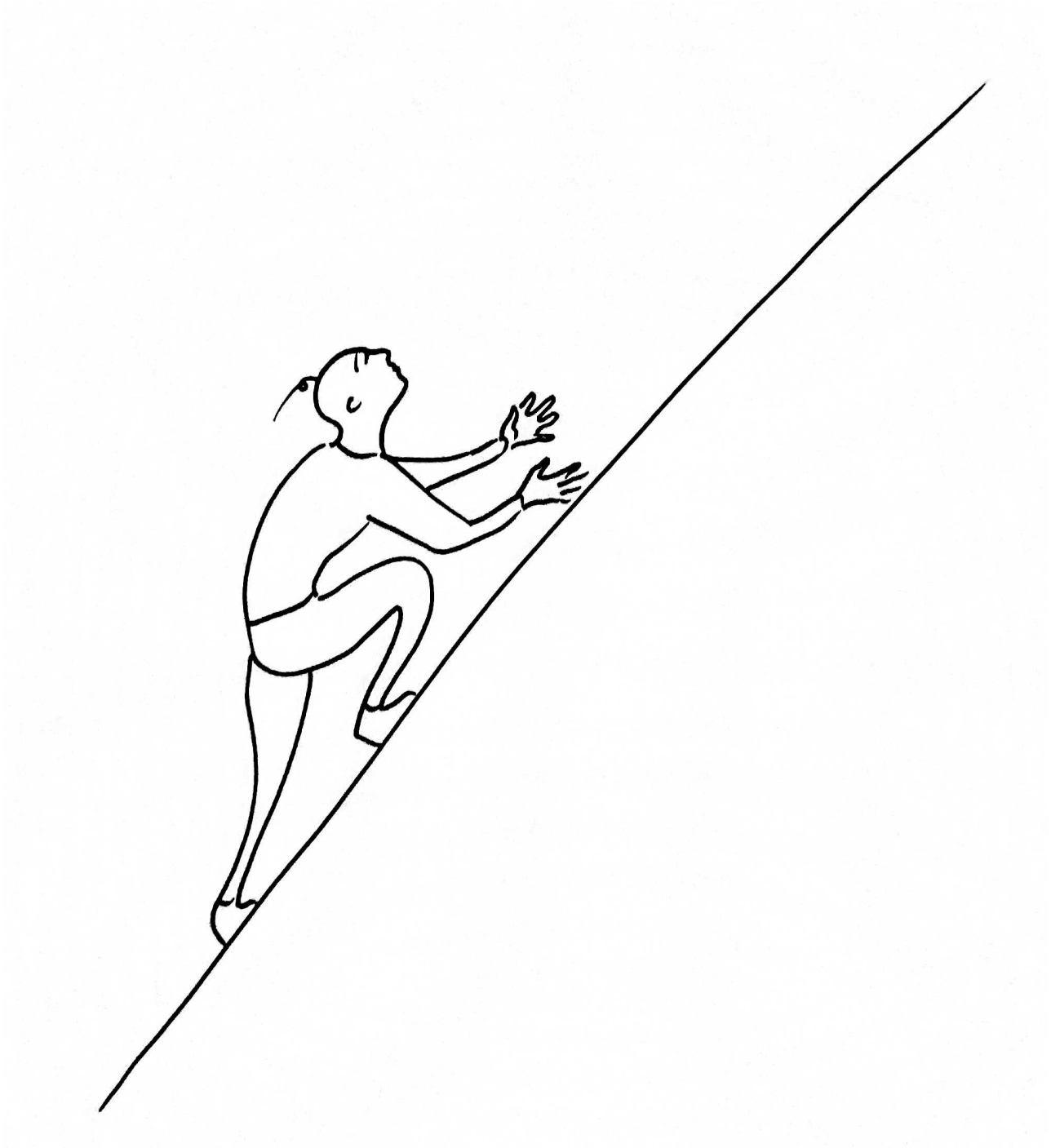

Mountain Work

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What is Mountain Work?

Mountain work is a metaphor. It involves imagining a scenario in which a village is bombed. It involves imagining a person sitting on top of a mountain, taking in the view of the harmed village. The task here is reconciliation between self (ego) and the reality on the ground, of causing – through one's actions – the damage, harm, repercussions, and human cost that exist now. This is a type of abuse-victimization-trauma (AVT)-existing reality (AVT-ER).

This type of reconciliation is a challenging process. In the metaphor, we see the person at first running down the mountain, needing many attempts to get to the top, and then finally opening one eye, peaking for a few seconds, and eventually being able to look. This may develop into being able to sit and really begin the process of "metabolizing," which refers to digesting what has occurred and making the necessary meaning of this reality, taking in the nutrients or learning that occurs, and transforming and changing as a result.

The goal is to come to terms with, and to accept, what has occurred. The goal is to accept the self, working toward adequate self-worth and eventually toward self-love. This is a form of psychological shadow integration.

Mountain Work: Psychological Shadow Integration Process and Practice

Shadow: The shadow is the part of the psyche, or ego, that contains all aspects the ego does not want to admit to as part of the whole organism.

Integration: The process by which a psyche becomes whole as the developing ego organizes; the state that results from countering the fragmentation of defense mechanisms.

Ego: The self; a human being's internal subjective reality of the self; the organized, conscious mediator between the person and external reality

Reality: The world or the state of things as they actually exist, as opposed to an idealistic or notional idea of them.

AVT-ER = Abuse-Victimization-Trauma (AVT)-Existing Reality.

Shadow Integration: A health-promoting psychological process of inviting with curiosity and making conscious those disavowed parts of reality and truth of the ego – the internal reality and truth about that human being, which consolidates the ego and creates internal power, ego strength, and capacity.

Healthy psychological integration creates health, strength, and internal power

1. The intersection of light and dark is alchemy; it fosters transformation
2. Many people attempt to find psychological health by pretending to be "all light" and utilize self-denial against owning their own shadow
3. This a weak, vulnerable, and often harmful and dangerous psychological state

Turning away and avoiding is normal

Turning away and denying any ATV-ER is a primal human protective instinct. It takes courage, willingness, and consciousness to overcome the primary instinct to turn away and avoid, which is why we use the strategy of ATC – Approach, Transition (ritual), and Conditions. For a person who caused harm, ATC includes mountain work specific to harms that have occurred to humans. For a person with deceptive sexuality, or a DCSR, this would be the DST-22 – the identified 22 traumatic sequences that may now exist – and the human suffering, often an abusive-injured existing reality and landscape, with landmines.

Note: Mountain work can be done both individually (as a personal self-study practice) and in a group context (with others who are also doing mountain work on any specific type of AVT-ER).

Task: Reconciling Ego with DST-22

1. Personal and progressive psychological process over time
2. It takes courage to go against the normal human first line of defense (the instinct to avoid and deny)
3. The abuser's version of eating elephant
4. Not just IAD behavioral containment, but learning about impacts on others as necessary and helpful for treating abuse problems

Mountain work for the abuser is intended to support the following health-promoting processes:

1. Psychological reconciliation process between self (ego) and reality of the AVT-ER (the DST-22 elephant)
2. Facilitates necessary ego maturation and health-promoting growth and consolidation
3. Facilitates organic movement from immature masculine psychology toward adult masculinity
4. Prepares for relational repair attempts and being an empathic witness for the survivor, where the abuser holds, resonates with, and vibes into the intimate partner's AVT-ER and with the vibrations of ISH (integrity, adequate safety, humility)

According to DSTT, the abuser (in the exposure phase) must come to terms (in the post-exposure and symptom progression phases) with the AVT-ER, which includes the village. The village is a metaphor for the gigantic DST-22 elephant, the reality of abuse, victimization, and trauma that now exists as a result of the DCSR. The gigantic elephant – in the psyche, in the relationship, and in existing reality – becomes difficult to simply ignore and just try to move on from.

This reconciliation process involves getting know, progressively, two realities

1. The reality on the ground; the AVT-ER; the damage, injuries, and human traumatic sequences
2. The ego (internal reality of the person as a human being)

The abuser needs to be engaged in a progressive consciousness-raising process and doing ongoing work to understand both **his EGO and the DST-22.**

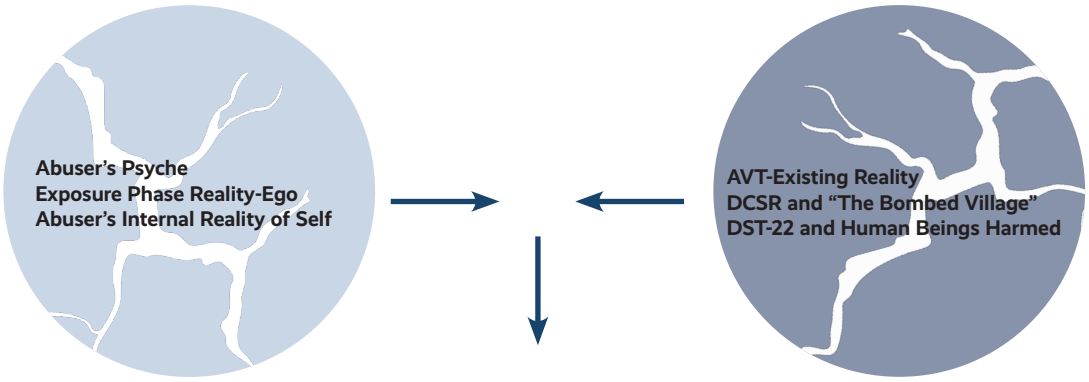
This includes getting to know, understand, and appreciate the ego story, which is the exact process the person in our metaphor used to get to the top of the mountain and to view reality. This process is referred to as a person's "ego through-line," where underlying factors and levels of the iceberg diagram are pieced together into a cohesive story that describes how the person has, over time, developed habitual patterns of thinking, feeling, relating, and behaving (i.e., personality characteristics, modus operandi).

Underlying factors may include:

- Coping and responses to life stressors and symptoms that influence our lives (Level 2)
- Personality factors (Level 3), habitual methods of thinking, feeling, behaving, and relating
- Sexuality shaping (Level 4) (e.g., sexual constriction – fear, shame, compartmentalization)
- Masculinity or gender shaping (Level 5) (e.g., sexual entitlement, emotionally crippled, lacking introspection)
- Complex trauma shaping (Level 6); attachment, abuse, maltreatment patterns that shape CTS-6 (the six systems of psychological function, and complex trauma shaping, that become the metaphorical spinal cord)

The initial phases of this reconciliation process can be particularly painful and challenging for anyone who is tasked with having to face AVT-ER as the abuser, or as the person who caused the harm. In the case of the exposure phase of DST for the abuser, the abuser's own ego often experiences a type of reality-ego fragmentation (REF). This may make it even more difficult to find the willingness, courage, and consciousness to turn toward and start metabolizing the reality/truth.

Abuser Reality-Ego Fragmentation (REF) and the Mask



Abuser's REF Symptoms may include:

- Exposure of the abuser's shadow
- Ego fragmentation or destabilization
- Masculine ego fragmentation, loss, and deflation
- Masculine humiliation, demotion, and impact to honor
- Organically in one-down position (not an equal)
- Destabilizing loss of denial-deceptive system-reality
- Acute stress and trauma from being responsible for repercussions
- Acute stress and trauma from DST-exposure existing-reality (AVT)

The abuser will need support and proper conditions to facilitate such a serious and sensitive human endeavor and undertaking. This is where the intentional clinical frequencies of ISH (particularly the vibe of **dignifying**) are key. They can take the abuser from a low place of degradation and lift them up by always reinforcing the truth of the worth of their humanity as a person, first and foremost. This is not a retributive justice model, but a decidedly and intentional restorative justice model and process.

Metabolization and reconciliation work is different for the abuser, victim, and abusive-injured relationship

1. **Victim.** Work involves making sure the victim is supported through a metabolization process of their own DST-22, often in a group context with proper conditions and procedures according to DSTT
2. **Abuser.** Work involves the abuser doing mountain work on the DST-22 and AVT-ER, often in a group context with proper conditions and procedures according to DSTT
3. **Relationship.** As a separate and very sensitive process, if chosen and consciously prepared, and only when sufficient stabilization conditions have been ensured, the relationship, as a third and separate entity, would be supported through whatever unique aspects of the AVT-ER and DST-22 may need to move through AVT-ER toward the organic rebound phase of post-trauma and abuse growth, regeneration, and renewal

Part of relational healing involves a stage where the relationship as a third entity may be able to face the reality of the injuries and the symptoms of what occurred and may still be occurring. For both people to do this, both need to "metabolize" first for themselves.

Key tasks in dealing with the AVT-ER

1. **Coming To Terms:** To begin (or least try) to understand, accept, and deal with a difficult or problematic person, thing, or situation
2. **Getting Over the Hump:** To manage or overcome an internal obstacle, impasse, or inhibition that is preventing one from succeeding or progressing
3. **Working Through it:** To move towards approaching to humanizing and help
4. **Dealing:** To manage or handle someone or something

A Process of Psychological Metabolization and Integration

1. Facing and dealing with the compulsive sexual behavior, lack of control, sexual behaviors, shame, and wounding involved
2. Facing, owning, and dealing with the dynamics of abuse-victimization (CES and IAD) and the consequent traumatic symptoms and sequences experienced by others and self
3. Facing and dealing with the reality of the impact of trauma on others, particularly the intimate partner or spouse, the relationship as a third entity, and sometimes the children and/or family system (DST-22)
4. Facing the story of the self and the underlying factors; making meaning of it (ego story)

Integration of the ego story

Shadow metabolization and integration may also include the work of integrating the ego story – the through-line of shaping and template-making – which is part of knowing the self and knowing your story and can be used as a resource for shadow integration work.

Mountain work prepares the abuser for relational repair
The additional benefit of mountain work is that it provides the precise type of preparation and support required for the abuser to be eventually able to gain skills related to the stage of relationship repair that involves metabolizing as a relationship entity, as a third a separate entity. This reconciliation process is preparation for the abusive partner to being able to sit, as an empathic witness, and facilitate potential relational healing by being able to hold and support the partner and the relationship. The reconciliation process helps the abuser develop the skills and the capacities related to the tasks of humanizing, sitting, holding, bearing witness, resonating, vibin', bleeding with (not for), attending, and eventually – with consciousness, courage, and effort – dealing better with the AVT-ER.

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Use of Educational Metaphor(s): 22 Rooms of a DST Hospital

Imagine a hospital specializing in the treatment of DST. One way of organizing this abuse and trauma is to utilize the 22 traumatic injuries and symptoms, and the three phases of DST, and using the metaphor of there being 22 rooms in this hospital. Hence this resource is organized in this context of 22 hospital rooms, with the choice to approach each one and better understand what has occurred to the people in each room. It is an educational metaphor used to help move the fragmented cognitive, emotional, and psychological reality into a system of stabilizing organization, structure, containment, externalization, etc.

Secret Sexual Basement: Deceptive, Compartmentalized, Sexual-relational Reality (DCSR) in the context of an intimate partnership and/or family system.

Workbook Organization - This resource provides:

1. First: Foundational psychoeducation on each room (injury-symptom)
2. Second: Simple stage 2 questions, worksheet(s), or ways to process and illuminate, educate, and then also try to help to reduce distress and incorporate into an ongoing assessment, diagnostic clarification and specificity, and treatment planning for that room.
3. Third: Simple stage 3 ways to facilitate deeper metabolization, for that room, when prepared and ready, and under the proper conditions-context-care.

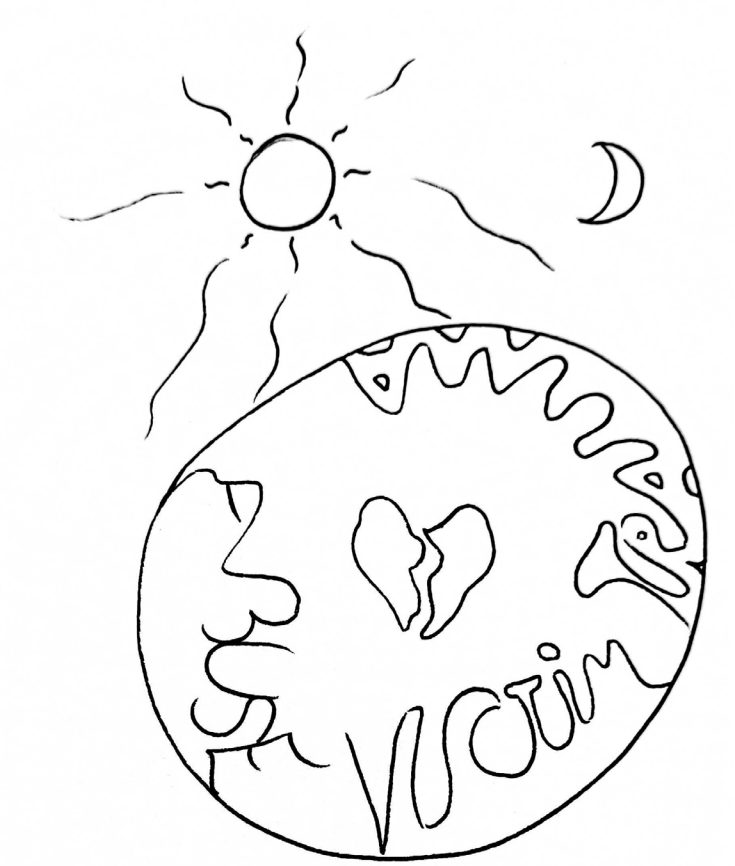
Proper Conditions-Context-Care:

This includes doing this work and applying the workbook under the professional care and guidance by a DST-Level 2 (minimum) trained professional, under the suggested conditions and in the appropriate clinical setting, practice and context.

Foundational DST Education and Concepts

Remember that a Recent Legacy of Oppression Exists in our Society

It is imperative to recognize the legacies of sexual and gender entitlement and sexual oppression and discrimination based on sexual and gender belief systems, themselves pathologically shaping outcomes that are normalized, unconscious, and largely unchallenged. This consciousness becomes most critical when treating gender or sexuality issues, which must be approached with the utmost care and clinical sensitivity, education, training, and skill. It is precisely because of the social shaping and the unhealthy biases and belief systems that inadvertently express in treatment that these individuals are at risk for treatment-induced harm and trauma. Further, the human beings who have suffered this type of harm consist of a group of people who carry a decades-long history of harm from institutions – this includes turning for clinical help and being misunderstood, pathologized, and mistreated. There is a decades-long treatment legacy of victims being treated as codependents, co-sex addicts, or part of the relational problem, all of which essentially blame the victim. This clinical, treatment-based, and professional structural discrimination is understood to exist not in a vacuum, but within a larger social context. The society at large has this same structural bias and tendency to victim-blame and to ignore/not understand the problems with victim-blaming, particularly for victims of abuse and trauma. Please hold this legacy in your awareness as you move through this space and interact with the people here. Examine and consider your own biases, particularly related to gender and sexuality. Remember that the DST Model asserts that we have all been shaped and mutated in unhealthy ways and share collective forms of gender and sexuality pathology.



Foundational Concepts of DST

Why the Term Deceptive Sexuality Trauma?

The specific term, deceptive sexuality trauma, refers specifically to the trauma that results from prolonged subjugation, over time, to the specific type of sexual-relational integrity-abuse and compulsive-entitled sexuality behaviors and patterns that are often experienced by victims of deceptive sexuality. This trauma often includes CTS that results from integrity abuse in all three phases of the trauma: the covert, exposure, and symptom progression phases (essentially before, during, and after the discovery of the secret sexual basement). The CTS involves a slow and progressive shaping of the victim's psychological systems over time: the self, relationship to the abuser, reality, the second brain system, relational integrity, and core functions related to identity (e.g., sexuality, gender, and body), attachment relationships, and systems of meaning.

DST is a term developed directly from victims of deceptive sexuality. It is highly specific and limited in scope compared to other types of traumas (which may be applied to many other injuries and contexts). For example, attachment injury or betrayal trauma may have nothing to do with deceptive sexuality at all.

Deceptive Sexuality Trauma (DST)

Deceptive sexuality trauma (DST) refers to both the traumatic injuries and the trauma symptoms experienced by intimate partner(s) and family members of people who engage in deceptive sexuality. Deceptive sexuality often involves the victimization of others through entitled sexuality and patterns of psychological, emotional, and relational abuse (or integrity-abuse disorder, IAD). Having been subjected to ongoing patterns of both compulsive-entitled sexuality (CES) and integrity abuse (IA) over time, victims of deceptive sexuality often experience a specific type of trauma and stressor-related symptoms known as DST.

The Deceptive Sexuality Trauma (DST) Model proposes that CES and IAD cause individuals to behave in ways that are abusive, that prohibit partners from being able to respond in healthy ways based on being informed about their reality, and that lead to significant traumatic symptoms and injuries for partners and family members. According to this model, deceptive sexuality – and associated patterns of psychological deception and manipulation – represent a specific type of system of abuse that causes a specific type of trauma.

Complex trauma shaping (CTS) is a key part of DST. Complex trauma is defined as repeated patterns of harm, with a consistent theme, over a prolonged period, in which the victim lacks a viable escape route or is disempowered. These experiences shape a person's psyche over time, like drops of water on a rock. CTS is a process that gradually develops in response to the long-term progressive patterns of psychological, emotional, and relational harm that are associated with sexual acting-out behaviors and integrity- abuse patterns. Many partners and family members of those who engage in deceptive sexuality also develop symptoms of complex trauma, which gradually develop in response to the long-term progressive patterns of psychological, emotional, and relational harm associated with deceptive sexuality. To organize our understanding of CTS, it may be useful to identify three ways of conceptualizing what has happened to the person:

1. **Complex Trauma Shaping the Six Psychological Systems**

   How has all the integrity abuse shaped the person over time in terms of their six psychological systems. In other words, complex trauma symptoms can include progressive negative alterations to:

   1. distortions in thoughts; lack of thoughts, thinking, consciousness
   2. emotions and how a person copes with emotions
   3. self-perception, self-contact and awareness, self-esteem
   4. how the person relates to other human beings; attachment functions
   5. perceptions of the abuser and the abuse; how the person relates to violence
   6. how the person makes meaning in their lives

2. **Complex Trauma Shaping the Triadic Care of Identity**

   The second CTS process is the progressive negative alterations to the person's self, identity, and core functions, particularly related to wounding of the three most sensitive tissues of the psyche:

   1. sexuality, sexual identity, sexual esteem, and sexual functions
   2. gender, gender identity, gender esteem, and gender functions
   3. the physical body, body image, physical appearance, and body-related thoughts and emotions

3. **Complex Trauma Shaping the Triadic Care of Identity**

   In the symptom progression phase, we see that the shaping process takes a toll not only on the primary attachment with the intimate partner, but also on a wide array of relationships and attachments. Here we can consider the metaphor of a stone thrown in a pond or water, where there is the "ripple effect," causing movement and change to areas that are not in the immediate location where the stone was tossed. CTS can impact the partner-child bond, the parental system, the family system, the neighborhood, and community relationships. CTS can shape how the psyche relates post-trauma to socializing, friends, strangers, public spaces, religion, and even life itself. Hence, CTS that results from deceptive sexuality may also impact relationships, injure attachments, and negatively alter interactions with, and trust in, other people. For example, DST may negatively impact:

   1. a person's reliance on their intimate partner due to relational integrity erosion
   2. children and the family system, including the parent-child bond
   3. a person's sense of community, social functions, and presence in public
   4. one's spiritual beliefs

"The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient's present symptoms and the traumatic experience is frequently lost." (Herman, 1997)

Room 1

Room 1: Covert Integrity-abuse Shaping

Covert Integrity-abuse shaping is being subjected to ongoing patterns and systems of compulsive-entitled sexuality (CES) and integrity-abuse behaviors and conditions (IAD) over time.

Covert Phase Integrity-abuse Behaviors

Covert phase integrity-abuse shaping refers to the integrity abuse that occurs during the covert phase of DST. During this phase, partners often do not realize what's happening to them – they are often not aware that the secret sexual basement exists. This lack of information leaves them effectively disempowered and without a viable escape route. Integrity-abuse behaviors and conditions during this phase include:

- Lying/lying by omission
- Deceptive tactics and manipulations
- Blaming the partner or relationship
- Intentional psychological manipulation of victim's reality
- Withdrawal and neglect
- Endangerment
- Corrosive narratives in order to justify

Under such conditions, this phase constitutes a form of covert domination and control of a human being(s). The ongoing behaviors and conditions that take place during the covert phase cause serious psychological, emotional, and relational trauma that can lead to both short- and long-term psychological, emotional, and relational symptoms.

It goes without saying that acts of sexual or emotional infidelity hurt human beings, violate negotiated agreements and commitments, and harm relationships. In addition, there are many other types of destructive behaviors and conditions that occur during the covert phase that have notable consequences. Indeed, once a DSCR is created, it requires an ongoing system of management that includes behaviors that are used to keep the basement hidden. Strategies are carried out in an attempt to hide truths, cover tracks, and manipulate people and situations in order to keep the DCSR from being discovered.

Some of the most common deceptive and defensive tactics (or integrity-abuse behaviors) that perpetrators use during the covert phase to protect and maintain a secret sexual life include:

Gaslighting. Gaslighting during the covert phase refers to abusers' intentionally manipulating their partners' realities (PRE) in order to keep the DCSR hidden (Dorpat, 1994; Dorpat, 1996; Gass, 1988; Jason, 2009). Abusers that actively gaslight redirect and distort their partner's reality in order to keep the sexual basement secret and to prevent the intersection of the PRE and the DCSR. Examples of active gaslighting behaviors include excuses for being late from work, lies about having to stay on a business trip for an extra day, presenting themselves to others as single, etc. Passive gaslighting refers to the presence of an unknown reality and considerable threat on an ongoing basis.

Lying outright, lying by omission, or telling partial truths. Lying or telling partial truths can seriously impact trust, reliance, attachment, and intimacy in a relationship (even if the lying or partial truth telling is "perceived" only at a deeply unconscious level).

Manipulating relational states. Sometimes the abuser will create specific states in the relationship for reasons that may have to do with the DCSR (e.g., suggesting that the wife looks tired so she may go to bed early and leave him the opportunity to have webcam sex with a person online; starting a fight to create a reason to leave home and engage in the DCSR). By creating these states, the abuser effectively creates self-doubt and self-blame in the partner as a way to get her preoccupied with her deficits. If she is preoccupied in this way, she is less likely to confront him or his deceptive behavior.

Using threats, anger, and intimidation to maintain control and power. The abuser may use subtle or overt forms of abandonment threats, financial threats, anger, and/or intimidation in order to keep their partner from inquiring about or discovering the secret basement.

Shaming and finding fault. Abusers may use shaming and finding faults in their partner as a way to create self-doubt in the partner and to keep the DCSR hidden.

Externalizing the blame. As relational problems and family symptoms emerge, the abuser may try to avoid responsibility by intentionally externalizing blame to the partner, the relationship, or other factors such as work. People who engage in secret sexual lives often need some sort of justification or rationalization in order to continue developing and maintaining their hidden worlds. It's just much "easier" to engage in deceitful and hurtful behaviors if you perceive the "fault" as stemming from the person that you're hurting. Unfortunately, these justifications/rationalizations often come at the expense of the unknowing partner. For example, the partner might be blamed by the abuser for problems in the relationship that were actually more likely caused by the secret keeping and the covert behaviors (in other words, by the perpetrator themselves). Because the abuser is unable to contain and contend with these types of negative attributions and emotions, they project them onto their partners and, as a result, feel justified in continuing their secretive and hurtful behaviors. Sadly, in the process, they also effectively erode their partners' sense of self-esteem, connection, and intimacy.

Covert Phase Integrity-abuse Conditions

In addition, just the creation and existence of a DCSR leads to abusive conditions, which, although they may not involve direct actions, set up a reality that is potentially abusive, oppressive, and harmful. These abusive conditions include experiences where victims consensually relate to a person and to a covert reality that diminishes and violates them, without their awareness. In fact, the very existence of a DCSR constitutes a system that prioritizes sexual entitlement and violates others' basic human rights, relational integrity, safety, and health. The presence of a DCSR dehumanizes intimate partners and family members, rendering them, at least temporarily, non-existent or as objects that need to be managed in order to "visit" the sexual basement and to keep it hidden. The person who created the secret sexual basement often develops a thought system that minimizes, justifies, rationalizes, denies, and/or defends their hidden reality. This, in turn, negatively impacts how the abuser perceives and interacts with their intimate partner and the relationship, likely for many years to come. The consequences of feeling entitled and of managing the duality of the PRE and the DCSR include disconnection and deep incongruence, each of which erode feelings of love and trust, thereby impacting attachment, intimacy, and happiness within the relationship.

Common abusive conditions that occur during the covert phase include:

- **Relational withdrawal and neglect.** Creating and maintaining a DCSR while in an intimate partnership often takes away time, energy, attention, intimacy, emotions, relational, and even financial investment from the relationship. As a result, the partner who is unaware of what is going on is left without the attention and nurturing that they deserve. On top of this, they are likely to feel confused and anxious as to why their partner is withdrawn and unavailable. One specific type of withdrawal that may occur during the covert phase is sexual withdrawal and neglect. Sometime the partner will be blamed for the lack of sexuality in the relationship because of issues such as weight gain, not being loving enough, etc. This can be particularly painful to experience, often resulting in the intimate partner feeling sexual rejection and low self-esteem. Having a secret sexual life can also rob children of the parental attention, time, nurturance, and devotion that play such a key role in their health and development.

- **Endangerment.** DCSRs are often associated with serious and potentially life-threatening risks, both for the abusers and the unknowing partners, as well as their loved ones and family members. Potentially hurtful and destructive risks taken on solely by abusers, without knowledge of, or consent from, their partners, may lead to immediate danger and/or long-term damage. Risks may include engaging in unprotected sex that goes uncommunicated. Or the creation of situations that could lead to other individuals' vengeful violence or retributive behaviors such as stalking or acting out on social media. Secret sexual lives ultimately create the risk of eventual separation or divorce. In addition, the risk of discovery of the DCSR places everyone at increased risk for severe damage and harm. Each of these risks is associated with heightened potential for negative and traumatic experiences that will impact all persons involved in the relationship, including the couple's children and other family members.

- **Covert dominance and control.** During the covert phase, abusers tend to have a significant amount of covert power and control over their partners, including coercive control (a catch-all term that emphasizes the core of most domestic abuse, which is the need for power and control over another person and incorporates numerous types of nonphysical domestic abuse patterns; Candela, 2016). By withholding important information from their partners, they effectively strip away their partners' ability to truly understand key aspects of their intimate relationships, along with the power to make healthy, self-protective decisions. Abusers who hold sexual secrets prevent their partners from taking action based on reality, and ultimately keep them paralyzed in a destructive pattern of uninformed immobility or chronic disempowerment.

There are some abusers who have convinced themselves that it is considerate and protective to intentionally keep their partners and family members unaware of the DCSR, as if it's an act of chivalry. This belief reinforces a sense of power and dominance and assumes that the partner and family members are too weak to handle the DCSR, that they need protection from it, or that they are somehow not worthy of being able to determine their own destinies.

- **Lack of informed consent.** Many partners in these situations engage in intimacy with the abusers without knowledge about the DCSR. In such cases, these partners are not consenting to intimacy based on complete information about the abuser and their deceptive sexual realities. Partners may even make life-altering decisions without full awareness of the truth (e.g., to have a child). Partners in these situations are robbed of the option to make fully informed decisions about and to provide fully informed consent related to their lives.

- **Breach of relationship agreements.** Involvement in a DCSR violates the primary relationship's agreement or contract related to sexual and/or emotional monogamy. Consider how this shape the abuser's perceptions of and feelings toward their partner, as well as the degree of investment they have for the relationship. Consider how an unknowing person living with a DCSR may react, at a gut instinct level, to living with ongoing sexual or romantic infidelities.

- **Dehumanization.** Abusers often need to compartmentalize, to an extreme degree, their feelings about themselves, their partners, and their family members. At some point, most abusers need to cognitively render their partners/family members as less important than the DCSR. This deprioritization leads to the dehumanization of people who are cared for and loved by the abuser.

- **Sexual entitlement over human rights.** A DCSR creates a condition where sexual entitlement is prioritized over the basic human rights of those who are being deceived. For the abuser, it is more important to create and maintain the DCSR than it is to allow people to know the truth so that they can make basic, informed life choices.

- **Social misrepresentation.** During the covert phase, the abuser might misrepresent their partner and the relationship. For example, they might communicate to others that the relationship is not monogamous (even when the partner believes that it is). They might lie and manipulate other people into believing that they have a hopelessly unhappy relationship, that they are almost divorced, or that they are single. As such, they might gain the trust and support of other people who unknowingly provide encouragement for the DCSR.

- **Social collusion.** During the covert phase, other people may know about the DCSR (e.g., a neighbor, friend, relative or coworker; or within corporate, military, community, or sports contexts) and intentionally withhold important information from the victim. This might also include other people who are violating the relationship by having sexual or relational contact with the person's partner. To the victim, this can be experienced as a form of social collusion against themselves, their children, and their family. The victim may experience it as a sort of community-level violation or betrayal that leads to short- and long-term emotional and psychological injury.

Male Sexual Entitlement

It is important to remember that sexual entitlement plays a huge role in the unconscious negotiation of masculine psychology as a way of coping. The secret sexual basement is an inherited way of living life and dealing with the intimate partner. It is likely no coincidence that in the English language there is the saying "ol' ball and chain" to denote a burden covered up with the concealer of supposed humor and jokes. This saying pokes at the truth of how men often feel and the stance they use when approaching intimate partnerships, dependent attachment relationships, and family systems.

Male sexual entitlement specifically espouses the belief that men are owed sex on account of their maleness. Some individuals view sex as a male right and privilege. Male sexual entitlement refers to a view that men have strong, and often uncontrollable, sexual needs that must be fulfilled and that women must serve that purpose (Hill & Fischer, 2001).

> Misogyny is "the law enforcement branch of the patriarchal order," while sexism is "the theoretical and ideological branch of patriarchy." In drawing a distinction between the two terms, we see that misogyny can survive without sexism, and that people can uphold misogynist structures without holding sexist views about women (Chotiner, 2020).

The secret sexual basement is a patriarchal and misogynistic structure, made of highly protected and durable wood, cement, and impermeable materials. Sexism is a key part of the thought system that creates, permits, and maintains the secret sexual basement, and relies on integrity abuse in order to do so.

Entitlement from (Perceived and Experienced) Victimization

- Victimization can breed resentment, anger, and rage, which are experienced as legitimate (i.e., justified anger)
- Justified anger can lead to a psychology of revenge or justice through action that is not perceived to be a violation or violent
- This emotional state – along with thoughts related to justifying the actions – can create a psychology of entitlement to violate, harm, and engage in aggression or violence toward others (which may include sexual entitlement)
- Sexual entitlement is more likely to occur when the victimization involves sexual or gender wounding
- The "Man-Box" and sexual proscriptions and prescriptions can foster reservoir of perceived and true victimization as a base of anger
- Perceived or experienced victimization by the feminine (maternal, chronic rejection by females, harm from the feminine) can contribute to increased anger, aggression, and entitlement to retaliate against and harm the feminine, girls, or women

How to Assess the Symptoms and Injuries from Covert Integrity Abuse

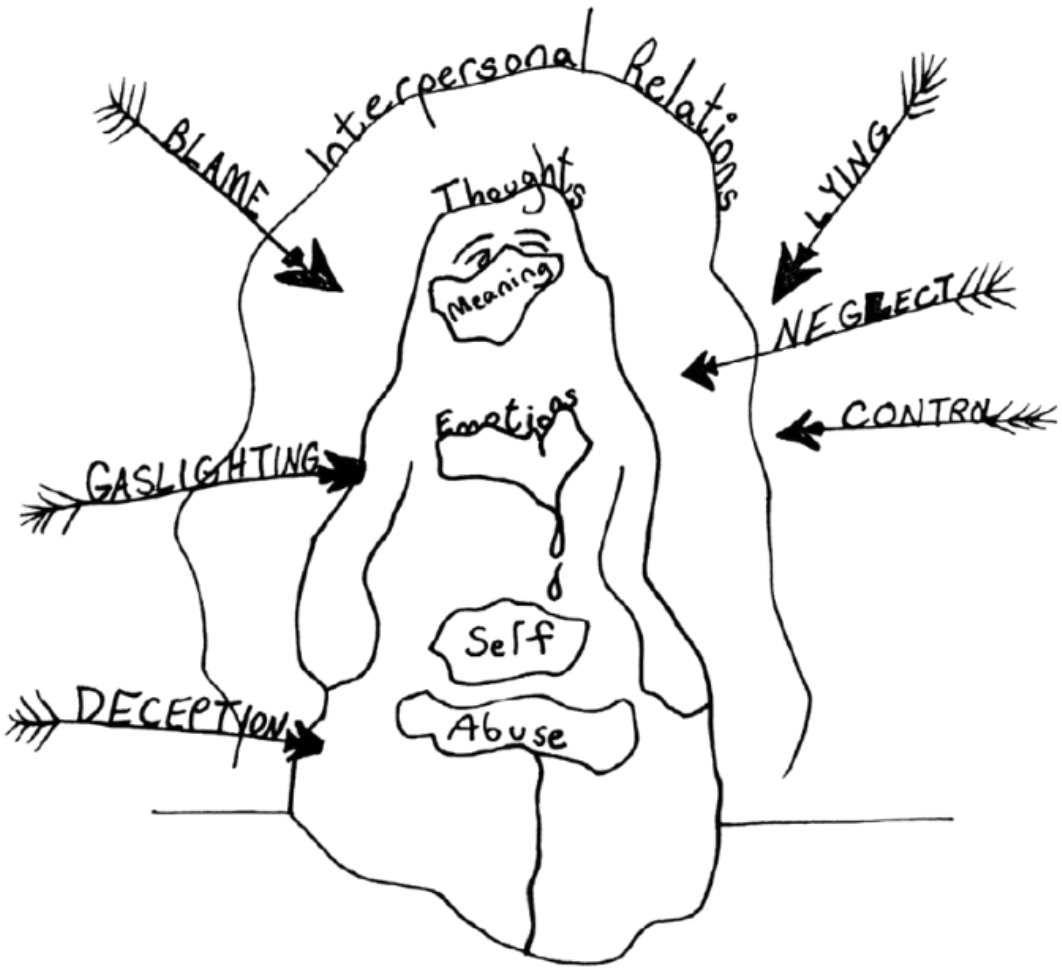
How it All Works: The Progressive Psychological Shaping Process

- **Step 1:** What are the patterns of harm that exist in this phase/room? What are the patterns of habitual coping that have been used to survive during this phase? Create a list of integrity-abuse behaviors and conditions that are in the room.
- **Step 2:** Notice how the harm and coping have shaped, over time (through complex trauma shaping), the person's six systems of psychological functioning (emotion, thought, self, abuse, relating, meaning).
- **Step 3:** Ask the victim how they were shaped over time in terms of the six symptoms of psychological functioning (emotion, thought, self, abuse, relating, meaning).
- **Step 4:** Assess how these six systems impact life today for the person. What is the status of these six systems of functioning now for the victim? Ask them for the current symptom status of the six shaping systems.

Covert Integrity-Abuse Complex Trauma Shaping

This refers to the integrity-abuse system, which includes all the behavioral patterns of lying, deceptive tactics, and manipulations, blaming and avoiding real ownership, defending (rationalizing, justifying, minimizing), and other patterns of harm, violation, and psychological-relational manipulation, etc. This includes the creation and the ongoing maintenance and engagement of a DCSR, while pretending to not have one with the intimate partner, children, and the family.

Under such conditions, this phase constitutes a form of covert domination and control of a human being(s). The ongoing behaviors and conditions that take place during the covert phase cause serious psychological, emotional, and relational trauma that can lead to both short- and long-term symptoms.



How was my partner shaped slowly over time in the covert phase before they really knew about the secret sexual basement?

How did these patterns shape the six systems of psychological function impacted by complex trauma shaping (CTS)?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

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Room 2

Room 2: Erosion of Enteric System and Second Brain Injury

Erosion of Enteric System and Second Brain Injury is being subjected to patterns and ongoing systems of psychological manipulation, passive and/or active gaslighting, resulting in negative alterations and symptoms to neurological enteric systems.

Erosion of Enteric System and Second Brain Injury

Room 2 is home to a devastating form of psychological abuse. Room 2 contains the injury and harm caused by psychological manipulation, covert coercive control, and gaslighting. During the covert phase, partners are likely to detect (consciously or subconsciously) threats in their environment; they are likely to subtly detect the presence of a secret sexual basement, even though they are not aware of it on a conscious level. However, these individuals often are not sure about where these feelings originate from. There is a fundamental incongruence between the victim's gut instincts and their partner's definitions of reality. As a result, victims may experience confusion. They may struggle to understand what is happening to them and to make sense of their second brain signals and survival impulses.

In addition, partners are often gaslighted by their abusers (Jason, 2009; Jason & Minwalla, 2009). Gaslighting (Dorpat, 1994, 1996; Gass & Nichols, 1988) is the process in which the abuser intentionally manipulates their partner's reality to protect reality and the truth from becoming known or discovered by their partner (Jason, 2009). If the victim decides to trust their partner's definitions of reality, the victim learns (over time) to distrust and ignore their healthy survival gut instincts. The victim loses their ability to depend on their internal system of detecting threats and propelling instincts to survive. In addition, they may eventually become generally hypervigilant and distrusting. Sometimes victims even become reliant on the perpetrator's reality and use it as an adapted "survival instinct." If the ability to utilize one's own intuition is so compromised and abused and/or if the victim has been manipulated into deep dependency and reliance on the perpetrator's definition and mandate of reality, then the victim may not be able to generate or act on emancipation impulses (so the idea of "just leaving" is not reality-based for some partners).

The point here is that in Room 2, infidelity, sex addiction, and deceptive, compulsive-entitled behaviors all rely on psychological abuse in the form of gaslighting. A DCSR is a system of passive and/or active gaslighting, and, therefore, represents an abuse problem with a traumatized victim(s). Even if there were no other integrity-abuse behaviors that existed, this room alone houses an abuse disorder and a form of psychological intimate partner abuse that can be devastating to its victims.

Interesting Reflection

It is probably not a coincidence that we say in the English language: “I felt it in my gut” or “I had a gut instinct.” The second brain and the enteric nervous system is the gut.

Educational Terms: Psychological Manipulation and Gaslighting Mechanics

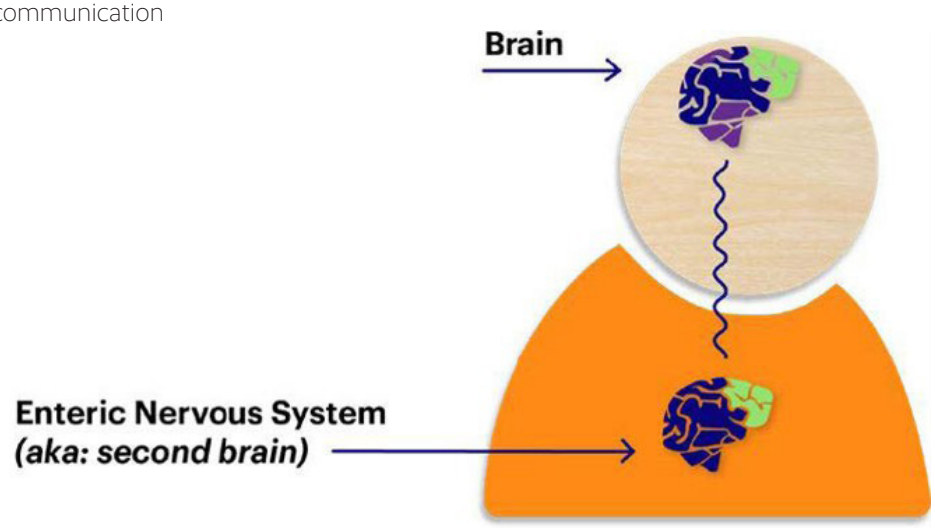
Intentionally Manipulated Reality (IMR): IMR is the manipulated version of reality that the abuser attempts to convince the victim's psyche of as the truth. The abuser will demand that the victim believe and adopt this version of reality. The abuser will insist that this becomes the narrative of what happened or is happening – existing reality (i.e., truth). The abuser uses IMR to control what the victim thinks, feels, and understands about existing reality.

Passive Gaslighting: The existence of a DCSR may cause the second brain and enteric system to become activated, detecting the threat of reality incongruences. By omission and continued manipulation, the victim is being gaslighted, meaning they are still having their reality intentionally manipulated so the abuser can maintain control of reality.

Active Gaslighting: Active gaslighting involves the intentional manipulation of reality (IMR) of another person, used as a deceptive tactic to support a deceptive agenda or strategy. Active gaslighting attempts to control and manage what the victim knows, preventing them from knowing specific truthful aspects of their actual reality.

Interesting Fact: Gaslighting is a tactic used by the military as part of psychological operations, used to weaken the enemy and as a strategy of war. This suggests that we do indeed recognize that gaslighting is harmful, and if applied in the domestic sphere or to intimate relationships, then it only makes sense to consider gaslighting as a tactical behavior that causes harm.

The Enteric System and the Second Brain
A sensitive system of survival-based communication



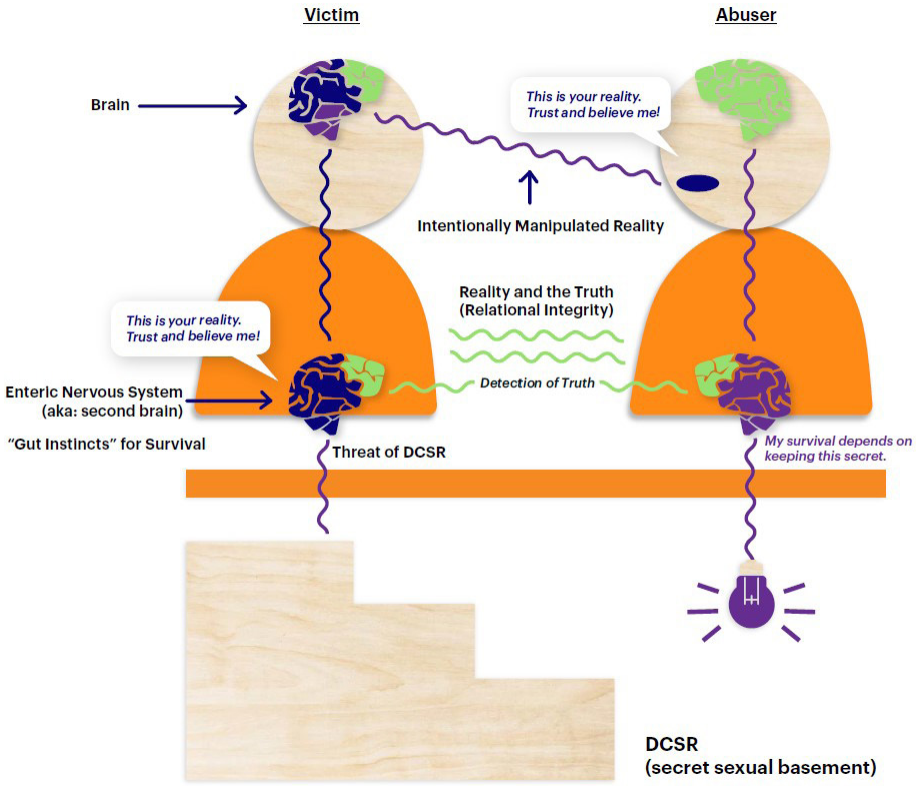
Important to Note:
According to Gass and Nichols (1988a):

Gaslighting is specifically described as a **marital syndrome,** observed in clinical practice – the exact same findings of the DST Model, 30 years later. So, ideas about gaslighting and male attitudes about infidelity are not new ideas or concepts. For example, back in 1988, Gass and Nichols described clinical observations and academic understandings of these topics:

"...certain male behaviors during and after their extramarital affairs and the impact of those behaviors and associated attitudes on the men's spouses...Not only the husbands but also male therapists may contribute to the women's distress through mislabeling the women's reactions and through continuation of certain stereotypical attitudes that reflect negatively on the wife whose husband has had an affair." - Gass and Nichols (1988)

Gaslighting Mechanics

Intentional Psychological Manipulation of Reality and Truth Second Brain Injury: Reality Incongruence



Subjecting the Person's Psyche and Brain to a System of Forced Choices

- Forced choice is the harmful and injurious position in which the abuser places the victim in a forced-choice situation. The victim is put in a psychological and neurological forced-choice position: either believe the abuser's demand and definition of reality (Door A) or believe and rely on the psyche's own detection system, including the second brain and enteric system, as well as all other sources of data (Door B).
- Whichever door is chosen, the other is harmed and negatively impacted (in terms of belief, reliance, trust, use, and utility).
- If the victim chooses the abuser's intentionally manipulated reality (Door A), then they are choosing to not trust or believe in their own sense of reality (i.e., their "gut instincts").
- If the victim chooses Door B, then they are choosing to not trust or believe in the reality that was being demanded by the abuser.
- Ongoing incidents of forced choice over time will create an erosion of either source – belief in the abuser's voice/reality or reliance and adaptive use of the victim's own sense of reality (specifically their enteric system and other neurological detection systems that may exist).
- This the meets the definition of coercive control (a catch-all term that emphasizes the core of most domestic abuse, which is the need for power and control over another person and incorporates numerous types of nonphysical domestic abuse patterns).

Dependency, Vulnerability, and the Power/Authority of the Perpetrator

According to betrayal trauma theory, the proximity between perpetrator and victim plays a significant role in the power differential that exists between the two. And the more powerful and authoritative the perpetrator, the more vulnerable the victim. The more vulnerable the victim, the less able they are to recognize the abuse as abuse.

This may or may not impact which reality the victim – the person being gaslighted – decides to trust and which reality the victim might sacrifice in order to preserve and optimize survival.

Betrayal Blindness (Freyd): The unawareness, not-knowing, and forgetting exhibited by people towards betrayal. Victims, perpetrators, and witnesses may display betrayal blindness in order to preserve the relationships, institutions, and social systems upon which they depend.

Is Gender a Factor?
It appears that men experience more non-betrayal traumas than do women, while women experience more betrayal traumas than do men.

Enteric System and Second Brain Injury

Subjecting a person to a DCSR may damage and erode the person's second brain and their ability to use this survival compass. The victim is subjected to a system of ongoing covert domination and control, where the abuser is controlling information that the person needs to survive. Instead of permitting the person to decide how to respond to reality, the abuser assumes control of the person and holds them hostage through ensuring a lack of awareness, and thus the ability to respond.

This type of injury involves placing the victim in the forced choice, second brain injury, relational attachment injuries, and results from complex trauma shaping of the person's enteric system and second brain, which injures a person's ability to rely on their gut instincts, causing systemic confusion due to the incongruence between the primary and second brain. This second brain injury impacts the victim's relationships as well as their ability to effectively experience, and respond to, survival and adaptive instincts.

Possible experiences of abuse or injury:

- Experienced patterns of intentionally manipulated reality (IMR)
- Subjecting the Person's Psyche and Brain to a System of Forced Choices
- Experiencing the forced choice between trusting self and senses versus voice of abuser
- The abuser will shape the narrative (power); dictates reality and version of reality

Possible symptoms:

- Confusion trusting one's "gut instincts", self, senses of detection, perception, interpretation
- Confusion, lack of trust or reliance on intimate abuser's voice and version of truth or reality
- Physical, somatic, and medical symptoms that are difficult to explain medically

How have the mechanics of psychological manipulation worked to negatively impact your partner's reliance and trust on their gut instincts or intuition, etc.?

How has psychological manipulation worked to negatively impact your partner's reliance and trust on your voice definition of reality, etc.?

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Room 3

Room 3: Erosion of Relational Integrity

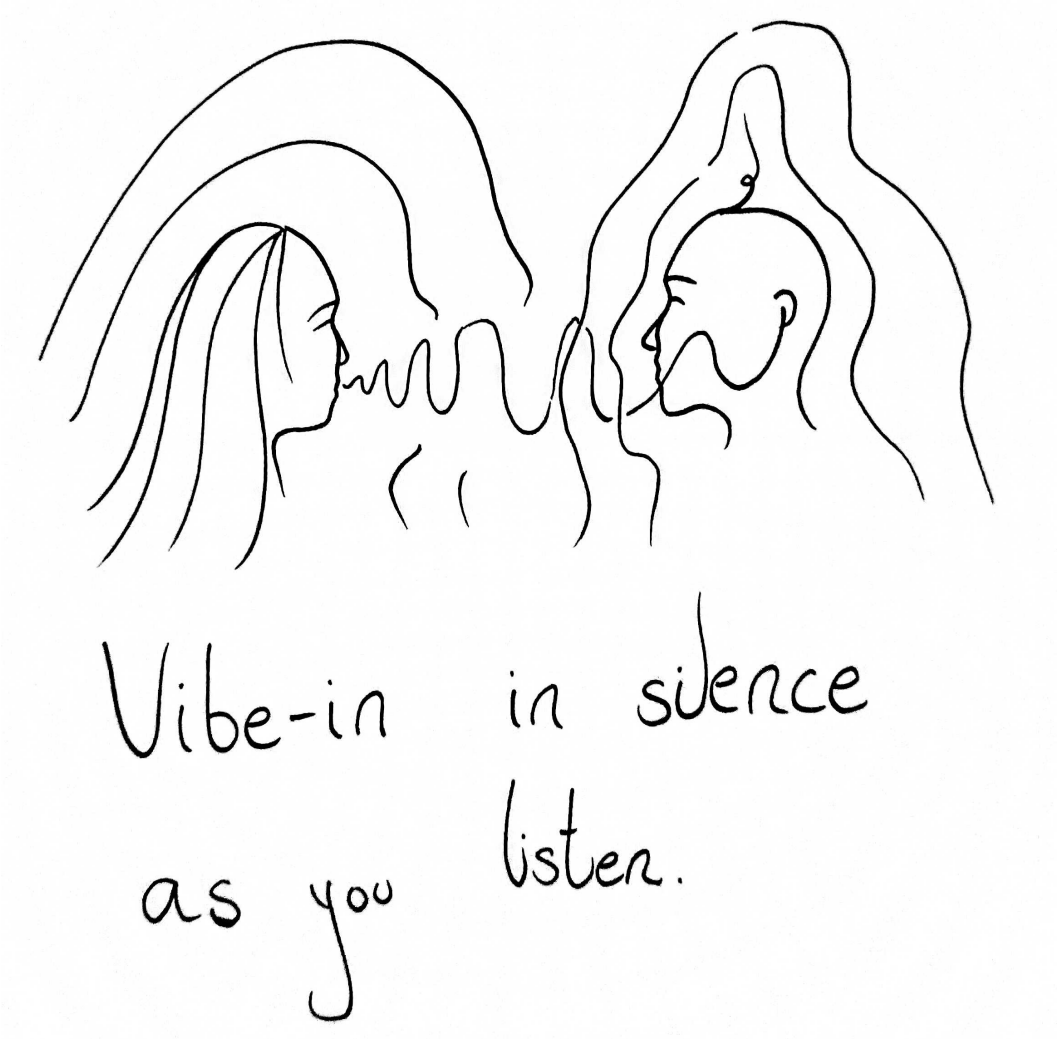
Erosion of Relational Integrity is being subjected to deceptive relational integrity vibrations that impact optional relational health factors progressively over time causing a weaking of the relational bond, attachment functions and energetic congruency.

Erosion of Relational Integrity

Another critical injury that can occur during the covert phase has to do with damage to relational integrity. To best understand this type of injury, we must take a step back and discuss the relational integrity theory (a theory that, though not conclusively proven, can be useful in understanding the symptoms and the course of relational progression over time, particularly in the covert phase of reality incongruence with a DCSR).

Relational Integrity Theory. Relationship integrity refers to the honesty, truthfulness, and authenticity that each partner brings to a relationship. Relationship integrity plays a huge role in determining how whole or complete a relationship is able to be. Relational integrity is not simply a belief in each person's mind, but an actual reality that exists between two people and separate from each person's individual evaluation or assessment of that reality.

High relational integrity is associated with relationships that are well able to transmit relational nurturance. When the energetic system is healthy (high frequencies and high congruence), the ability for these vibrations of nurturance to be transmitted (transduction) is optimized, and relationship integrity is strong. The idea of having a "strong bond" can be a common way of describing high relational integrity.



Relationship Integrity as an Energetic System

The theory of relational integrity proposes that integrity is part of an energetic system that exists between human beings. This theory states that the degree of authenticity and truth expressed between two people creates an energetic system between the two people. Within this system, each person transmits an energy that is associated with the degree of truth, authenticity, and transparency that they bring to the relationship. The energy submitted by each person, in turn, creates a type of relational energy between the two individuals that plays a big role in determining the integrity of the relationship. The idea of having "a nice flow" in a relationship, or "good energy" may be descriptions of this energetic system of openness and honesty that exists or is experienced in a relationship.

The energetic system that we're talking about can be broken down into three, interdependent parts:

1. **Relational Frequency.** Similar to electromagnetic or sound frequencies, the frequency of integrity transmitted by each person, creates an actual frequency between human beings. The more honest, authentic, and transparent a person is with their partner, the higher the frequency they will transmit. Higher frequencies, in turn, increase the health and wholeness of the relationship.

2. **Relational Integrity Congruence.** When the energy between two people is flowing with the same or harmonious frequency, this creates high relational integrity congruence. When relational energy is congruent and flowing with the same or harmonious frequency, then the energy of the system is whole, strong, and stable. The term of being "in sync" may be one way of conceptualizing this idea – when two people are very honest and truthful with each other; they create a synchronized, consistent energetic system that flows harmoniously.

3. **Relational Transduction.** Relational frequency and congruence impact the strength and stability in the bond between two people through relational transduction. Relational transduction is the ability to transmit vital relational nurturance such as love, a sense of closeness, and the communication of care or unconditional regard. The higher the relational frequency and congruence, the easier and faster that these types of relational expressions can be transmitted to the other person. These types of essential energetic vibrations nourish and provide sustenance to the other person and to the bond itself.

Similar to sound waves or electromagnetic waves, the more honest and transparent the energy transmitted by a partner, the higher the frequency of their energetic waves. In other words, their energy waves will be more rapid, less fluctuating, and more consistent. When both people in the relationship transmit high degrees of truth and authenticity, their waves will flow in harmony, in the same direction, with a consistent pattern, and in a way that does not clash with the other person's energy waves. With low levels of interference and few obstacles in their paths, these waves can transmit a high amount of data easily and at a rapid pace.

Deceptive sexuality causes an imbalanced energetic system.

Unfortunately, when there is ongoing system of deception or lies within a relationship, the person involved tends to emit specific types of energy waves that result in an imbalanced energetic system:

1. **Low Relational Integrity Congruence.** When the energy between two people is flowing in different directions and/or at dissimilar frequencies, the relationship will experience low relational integrity congruence. This will weaken the bond between the two people and make the relationship feel less safe, stable, reliable, and secure.
2. **Low Relational Transduction.** With low relational integrity congruence comes interference and slowing down of the processes involved in transmitting relational nurturance. Opportunities and abilities to provide emotional and psychological nourishment will be decreased, as will feelings of love, care, regard, and connection.

When an energetic system is imbalanced, it suffers from low relational frequency. Low relational frequency creates much larger waves that travel slower than high frequency waves. These waves move incongruently and interfere with each other, essentially clashing with each other repeatedly and disrupting the flow, direction, and patterns of the whole set of relational waves. This type of interference causes significant disruptions and an erosion of the waves' ability to transmit information.

Human beings can experience an energetic shift within themselves – their own body and psyche – when they lie or are dishonest, for example. The energy that is created by a lie is the exact vibrational shift that is considered toxic and potentially harmful.

A deceptive, compartmentalized sexual or relational reality (DCSR) negatively impacts a relationship's energetic system. More specifically, a DCSR fragments the energy that exists in the relationship and creates a different frequency that is highly incongruent with the energy of the system as a whole. This creates erosion, corruption, and a progressive weakening of the relational bond. This destruction is sensed and experienced by both partners within the relationship. This energy is sensed by both our conscious brain and by our second brain, which houses our gut instincts.

This is why a DCSR is so damaging to relational integrity and to relational health as a whole. It is not just a simple lie about something specific. It's actually an entire system of deception that is maintained over time, and what's being hidden and kept secret is of a highly volatile nature. It's the creation of an entire world and reality that is intentionally hidden from the partner.

The DCSR creates a very low frequency in the couple's energetic system (large waves that move slowly) that clashes and causes interference in the system as a whole. It limits transduction, meaning that the couple will have difficulty with relational nurturance and connection. One way to describe this is that their open lines of communication will be cut off.

Often this damage is done to the relationship (sometimes for many years!) even before the partner learns of the sexual betrayal. The damage can include symptoms such as:

- a sense of disconnection
- a decrease in the ability to absorb intimacy or love
- a weakening in the ability to depend on, or feel stabilized by, the relationship
- increased feelings of isolation and loneliness in the relationship
- fewer expressions of emotional nurturance
- increased likelihood for avoidance – including avoiding sexuality and physical touch
- increased feelings of aversion and emptiness in the relationship

Whether the victimized partner is conscious or aware of the deceptive sexual system or not, there will still be ongoing damage to the integrity of the relationship. Even if the perpetrator attempts to control or mitigate the damage, the damage will still occur. Even if the perpetrator stops engaging in the behaviors at any point in time, the ongoing and progressive damage will continue. Once the DCSR has been created, it will consistently emit very low frequency waves of deception and violation, which will cause significant interference of the vital transduction of basic relational energetic nurturance and communication. These low energetic patterns will cause people to "grow apart".

Interesting Reflection

It is probably not a coincidence that we say in the English language: "I am not feeling it" or "We have good vibes…good energy."

Relational Integrity

Definition of Relational Integrity: The degree of integrity or authenticity that exists between two people - an energetic system.

High Relational Integrity

"Good Vibes"

Description of High Relational Integrity:

- Transmission is optimal
- High frequency energy waves
- Congruence between waves
- Flow is harmonious

Optimal transmission allows for emission, transmission, and absorption by the other, permitting optimal sustenance to the relationship, which allows the relationship, and each person in it, to experience vital relational nutrients such as:

- Nurturance
- Care
- Support
- Love
- Dependency
- Security
- Respect
- Loyalty
- Positive regard
- Esteem

Low Relational Integrity

"Not Feeling It"

Description of Low Relational Integrity:

- Transmission is weakened, diminished, eroded
- Low frequency energy waves
- Incongruence and interference of waves
- Flow is interrupted, clashes

The erosion of transmission leads to a decreased ability to absorb nutrients and may cause the following relational symptoms:

- Weakening of ability to depend on the partner
- Decreased security or stabilization in attachment
- Increased feelings of isolation within the relationship
- Fewer expressions of emotional nurturance
- Increased likelihood of avoidance (sexual, touch, time)
- Increased feelings of emptiness
- Increased feelings of aversion to the other and the relationship

Erosion of Relational Integrity and Relational Health Factors

Relational integrity erodes progressively over time, weakening the ability for strong connections and the ability to transmit vital relational health nutrients in the relational energetic system. This may cause symptoms and problems in the relationship, way before the discovery or disclosure of a DCSR. Sometimes these relational symptoms are used to justify or rationalize the DCSR and to further blame the relationship or partner.

Relational frequencies, or health factors, optimally experienced with high relational integrity systems; energetic system optimal in transmission of:

a. love
b. nurturance
c. care
d. support
e. security
f. respect
g. dependency
h. loyalty
i. positive regard
j. esteem

Relational Symptoms with deception eroding and changing frequencies, eroding potential for relational integrity:

a. weakening of the ability to depend
b. decreased security or stabilization in attachment
c. increased feelings of isolation within the relationship
d. fewer expressions of emotional nurturance
e. increased likelihood of avoidance (sexual, touch, time)
f. increased feelings of emptiness
g. increased feelings of aversion to the other person or the relationship itself
h. a sense of disconnection
i. a decrease in the ability to absorb intimacy or love
j. a weakening in the ability to depend on, or feel stabilized by, the relationship
k. increased feelings of isolation and loneliness in the relationship
l. fewer expressions of emotional nurturance
m. increased likelihood for avoidance – including avoiding sexuality and physical touch
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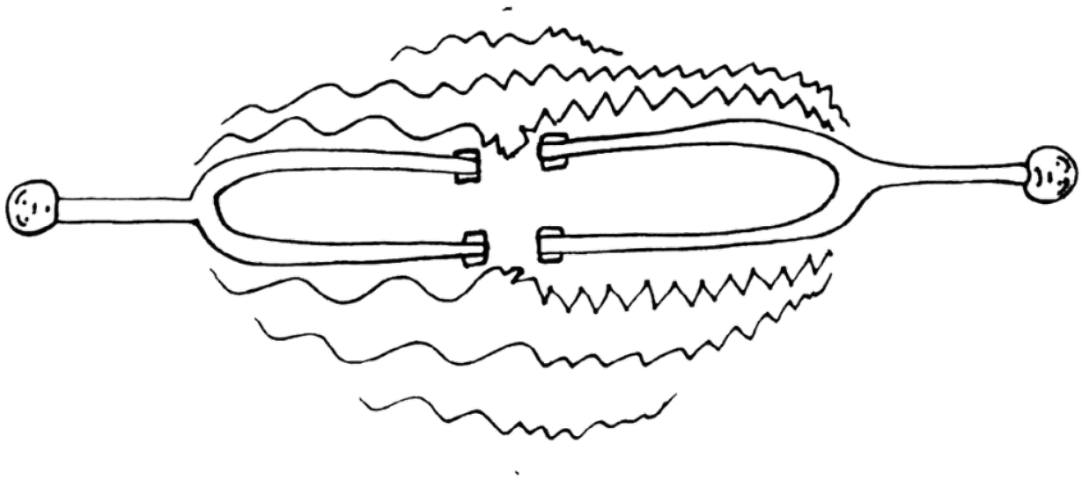
Do any of these apply to you? If so, how?



How were the vibes in the relationship and home prior to discovery of the secret sexual basement?

Were there any changes or progression of relational or other symptoms?

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Room 4

Room 4: Exposure Phase Integrity-abuse Shaping

Exposure Phase Integrity-abuse Shaping is being subjected to continued, escalated, sometimes different types of integrity-abuse, during the intersection of the two realities (PRE and DCSR).

Exposure Phase Integrity-abuse Behaviors

Exposure phase integrity-abuse shaping refers to the integrity abuse that occurs in the exposure phase of DST, during which the partner's pre-existing reality-ego (PRE) intersects with the DCSR. In this phase, the previous perceptions and structures of reality are exposed to the secret sexual basement. This process represents a specific psychological injury that is referred to as reality-ego fragmentation (REF).

During the exposure phase, the victim is often subjected to intensified integrity violations and patterns of psychological, emotional, and relational abuse (i.e., integrity abuse disorder or IAD). The person who created and has been maintaining the secret basement will often try to defend themselves and to protect the truth from being exposed by utilizing specific defenses, often immediately after the initial discovery of the DCSR. Some abusers will engage in very aggressive and overt forms of verbal abuse, threats, and intimidation. After doing so, they might attempt to claim that the victim's reactions in response to these behaviors are actually the cause of the relationship's problems. In other words, abusers in these situations will turn the victim's traumatic reactivity and symptoms into the problem and will reconceptualize the victim as the perpetrator in an attempt to deflect from the real issues. Some of the most common types of integrity-abuse behaviors that occur during the exposure phase include:

Denial and obstruction. A common first line of defense is denial and obstruction. Some abusers will overtly deny the existence of the DCSR by stonewalling, refusing to speak or listen to their partners, lying (discussed below in greater detail), using cover-up narratives, and/or destroying or hiding evidence. Many will attempt to minimize the nature, frequency, duration, and/or content of the behaviors as well as the intention and meaning of the behaviors. Abusers will often try to deny how significant and impactful the DCSR is to the victim.

Defensive distortions. Defensive distortions refer to the ways that abusers twist and manipulate reality into different configurations in an attempt to shape victims' perceptions of truth. For example, minimization may be used to try to make things seem less significant or meaningful than they actually are (e.g., the frequency of DCSR behaviors was lower than it really was or that the affair "meant nothing"). Rationalizing and justifying are additional forms of defensive distortions that are also common during the exposure phase.

Psychological manipulation and gaslighting. Feigning ignorance, confusion, or innocence and pretending to not recall or remember are tactics that might be used to manipulate victims during the exposure phase. Psychological manipulation such as countering and correcting (Jason) might be used to defend against actual responsibility-taking, to avoid confrontation of the truth, and to create self-doubt in victims.

Lying. Lying (i.e., overtly lying, lying by omission, and intentionally holding back information that is clearly relevant) is another common integrity-abuse behavior. In fact, some abusers will continue to lie even when there is hard evidence to contradict their inaccurate version of reality. Some abusers might only admit to what the victim already knows and continue to hide the rest. These abusers will often attempt to determine how much is necessary to share, and what can remain deceptively compartmentalized. They will present false, staggered, or partial disclosures as full disclosures and continue their control and domination over their victims by withholding the complete reality. Lying injures trust, violates the victims' right to the truth, and robs the relationship of its relational integrity.

Externalizing blame and victim blaming. If the DCSR is unable to be completely withheld, defenses such as externalizing blame and victim blaming may emerge. Blame might also be assigned to work, stress, other people, drugs or alcohol, etc. More often, however, the intimate partner or the relationship itself become the targets of blame and are cast as at least partly responsible for the DCSR. Sometimes an intimate partner's body or their lack of sexuality, affection, or attention will be used to justify the DCSR. Oftentimes, victims' symptoms that developed during the covert phase are used by abusers as justification for victim blaming during the exposure phase. This often leads to direct attacks, fault finding, and/or attempts to create self-doubt, guilt, or shame in the victim.

Domination, power, and control tactics. During the exposure phase, abuser will often express anger and rage at having been caught and/or confronted. Abusers may become verbally abusive, using tactics such as belittling, patronizing, and chronically diminishing. Abusers may also use passive-aggressive threats, violence or the threat of violence, and other forms of domination in order to control, silence, suppress, and oppress their traumatized partners. Withdrawal or threats of abandonment, including financial abandonment or removal of basic financial support, may be used to manipulate victims or to maintain power over them and to stay in control.

Continued engagement in the DCSR. Some abusers may continue to engage in the DCSR and to hide, lie, and manipulate even after their partners have been exposed to the previously secret reality. Despite the injury, trauma, and pain experienced by the victims during the exposure phase, some abusers' sense of entitlement will prevail in these situations, and the DCSRs continue. The abusers in these situations may have promised to stop their compulsive-entitled sexual behaviors; however, at some point they return to their secret basements and re-engage in deception. This sets up the situation for yet another discovery/disclosure and reality fragmentation process.

Exposure Phase Conditions

Integrity abuse during the exposure phase is conceptualized as not only abusive behaviors or conduct, but also as the following abusive conditions or states of being:

- **Integrity-abuse bombardment and flooding.** During the exposure phase, the frequency and proximity of the behaviors described in the previous section often lead to the victims feeling bombarded, overwhelmed, and unable to prevent the behaviors, to stop them, or to effectively cope with them. The experience of being subjected to integrity abuse and not being able to prevent, stop, or effectively cope with it because it keeps happening in rapid succession itself becomes an injurious condition. When there is integrity-abuse bombarding and flooding, the victim has no space, time, or ability to metabolize the abuse or injury. During the exposure phase, victims often experience a series of shocking events, allowing them no time to process or deal effectively with those events. The constant exposure to new abuses and injuries render the victim unable to use healthy or adequate coping mechanisms. This pattern can turn into a complex trauma shaping process that impacts the victims' emotional, cognitive, and relational systems and gets more harmful as the abuse lasts longer, occurs more frequently, and gets more severe over time.

- **Avoidance of responsibility.** One of the first steps in effective coping and healing involves identifying the problem as well as its source. An important part of this step is that the source (person) must take responsibility for their role in creating and sustaining the problem. If the source does not do this and instead denies or does not comprehend the situation, it becomes that much more challenging for the victims. As such, it makes sense that victims often feel a strong drive to get the problem clearly identified and to ensure that the deceptive partners take ownership. However, this process often takes time and tends to involve a number of harmful behaviors (e.g., defensive behaviors as well as escalating deceptive, manipulative, and abusive behaviors) that get carried out before responsibility is taken on by the abusers.

- **Lack of detailed disclosure about the DCSR.** During the exposure phase, it is not uncommon for abusers to deny the victims access to the truth and reality of the DCSR, despite how important it is that they gain a truthful, accurate, and full clear disclosure. For intimate partners, being prevented from access to this information can be an excruciating and harmful experience to which they may respond with anxiety, anger, and rage. This can often create intense additional injury, trauma activation, and stress for the victims. Indeed, every moment that passes during which the victims are denied crucial information about the DCSR takes them farther away from embarking on their healing processes.

- **Protection of self over others.** Many of the behaviors that occur during the exposure phase communicate to others that abusers value themselves over their partners and family members. Rather than responding to their victims' need for important information as a step to treatment and healing, abusers will instead often choose to defend the DCSR and themselves. This often creates an injurious dynamic for the intimate partners, which can lead to high levels of fear, anxiety, anger, and rage in an effort to deal with the pain of the situation.

- **Lack of space for partner's pain.** The abuser's state of mind and inability to face the reality of the situation may result in a lack of space for and appreciation of their partner's pain. Indeed, the abuser may even sometimes show intolerance towards the intimate partner's symptoms and may become abusive if the symptoms are expressed in his or her presence.

- **Domination and oppression.** During the exposure phase, victims are often not allowed gain the information they need about the DCSR. They are not allowed to express or to sort through the extreme pain that they feel. They are not given the chance to tend to their needs and to start their healing processes. Sometimes abusers actually dictate what emotional and behavioral reactions and expressions are allowed by their victims. Some abusers will determine what their victims are permitted to express, how much they may be allowed to express, and in what ways they are permitted to express themselves. Victims in these types of situations often feel hopelessly deprioritized, dominated, disempowered, and oppressed.

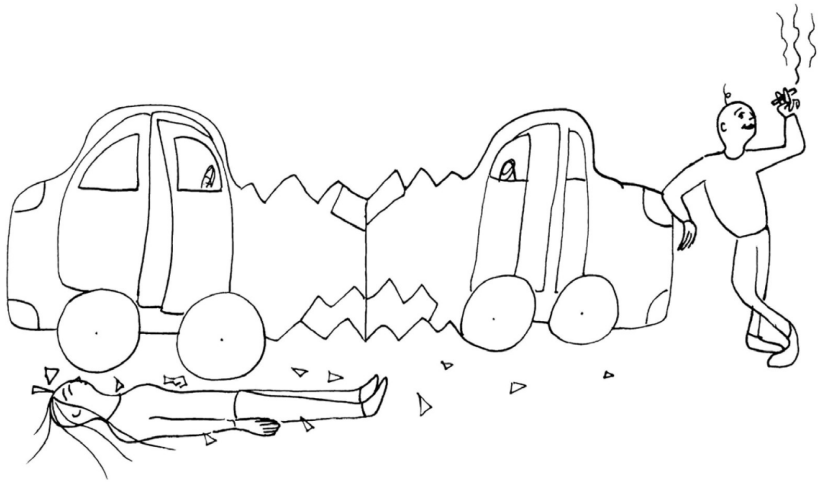
- **Inability to provide valuable care and support.** If abusers do not take ownership, remain in denial, and/or lack basic comprehension about the problem, then it is unlikely that they will respond to their victims in ways that are healthy and helpful. In these situations, they are unable to act in ways that would help put the traumatic dynamic and process on a path towards recovery and health, repair, and healing. Abusers in this situation are often not able to provide the safety, emergency care and protection, or health-promoting support that would be so beneficial for their partners and families.

- **Demand for immediate equality.** Abusers will often deny or lack awareness about the impact, intensity, or injuriousness of the situation. In fact, they will often act as if nothing is wrong and expect to be treated as they were before the DCSR exposure. They may demand immediate relational equality, sometimes attempting to get it through control, domination, or abuse (e.g., demands for sex or other expectations that are unhealthy and/or abusive). Insistence on immediate relational equality suggests that the abuser does not truly recognize and take responsibility for the level of injury that they have created.

- **Social misrepresentation.** There may be times where the abuser and the victim decide together to shape the narrative about their relationship and the DCSR to others in their family or communities in ways that attempt to protect the family or to minimize negative impacts on children. There might also be disagreements between the abuser and the victim about what to share, with whom to share, how to share, or when to share. But there might also be situations in which the abuser decides on their own to manipulate the narrative, effectively dominating, dictating, and rendering additional abuse on a social level. There may be times when this type of abuser directs who, when, how, and what (if anything) is shared with others, including children, other family members, friends, and communities. Abusers in these situations might choose to present their partners, relationships, or families in distorted ways to other people, thereby creating inaccurate social perceptions that can be devastating to victims.

Educational Metaphor: Driver Gets Out and Lights up a Cigarette

Imagine a car crash. Imagine the driver at fault for the car crash getting out of his car after the accident and lighting up a cigarette as he looks at the people injured and bleeding on the road.



IMPORTANT NOTICE TO ALL: CLUELESS MEANS CALLOUS

When we do not recognize the car crash in front of us – when we do not identify abuse as abuse – then we are likely to approach the situation in a way that is clumsy, callous, and insensitive. Being unaware and not seeing the problems that exist make it difficult to respond in a healthy way. In other words, being clueless means being callous. Abusers that don't recognize themselves as such are likely to engage in continued integrity-abuse behaviors after their victims discover the secret sexual basements. In such cases, the victims do not receive the immediate help and assistance that they so desperately need and instead endure continued abuse.

As a reminder, here are some of the integrity-abuse behaviors that occur at the scene of the car crash:

So the first important point is that most abusers (and society at large, including even therapists) do not yet see clearly, easily, or immediately the car crash created or the injured persons on the road. To the extent that abusers (and others) do not see a problem, they are likely to interact with callousness, clumsiness, and insensitivity - just by default. In essence, everyone is basically walking around and over the person on the road as if nothing really happened.

The second important point to consider is that, at the scene of the accident, the driver is often highly symptomatic and reactive – in a post-traumatic state and context. Before the accident, the abuser's psychological stability had – at least in part – depended on the separation of reality between the DCSR and the PRE. Now that the two have collided, the abuser is in survival mode, still trying to protect the secret sexual basement from further exposure. Now that the abuser has been "discovered," they are in high survival reactivity mode – they are focused on defending and protecting themselves from further consequences and attempting to minimize the intersection of the two realties. The abuser is now also experiencing a form of reality intersection and fragmentation – their ego, self, the person they thought they were also now shattering. In addition, their safety net and go-to-person is also suddenly lost, which throws the abuser's psyche into a state of vulnerability and post-trauma reactivity. Thus, the abuser mobilizes to protect the basement against the people in the house, going against the natural instinct to go help the injured motorists.

The third point to recognize is that there was a DCSR in the first place, which clearly illustrates that the abuser lacks integrity and suffers from an integrity-abuse disorder. So, what should be expected in the aftermath of the car crash? It is a normal human reaction after hiding or deceiving others – when caught and confronted – to deny, lie, and demonstrate the same lack of integrity here. Here we will see played out the habitual methods of maladaptive feeling, thinking, behaving, and relating to others that are associated with the integrity-abuse personality characteristics that led to the CES, IAD, and DCSR. Deficits in conscience (or character disturbance) are associated with responsibility-avoidance behaviors and manipulation tactics, many of which are also integrity-abuse behaviors used by deceptive sexuality abusers (Simon, 2011).

Exposure Phase Integrity Abuse

- Lying/lying by omission
- Deceiving, hiding, manipulating the truth
- Gaslighting (intentional psychological manipulation of the victim's reality)
- Externalizing responsibility
- Blaming the intimate partner or relationship for the DCSR
- Denying the problem or the disorder and its actual consequences
- Continued sexual-relational violation behavior (overt infidelity or DCSR)
- Minimizing
- Rationalizing
- Justifying
- Projecting
- Denying
- Covering-up
- Partial disclosures
- Revising facts and history
- Obstructing
- Stonewalling
- Refusing to cooperate or to speak
- Technical manipulation
- Verbal abuse or diminishment
- Intimidation and threatening
- Being aggressive or passively aggressive
- Equivocating
- Withdrawing
- Abandonment
- Feigning innocence or ignorance
- Assuming the role of victim
- Fault-finding
- Demanding immediate equality
- Frequent or rapid integrity violations or abusive actions
- Shaping the narrative
- Defying logic or reason as a protective tactic
- Shifting focus to the abuser's pain
- Selective attention or memory
- Callous / cruel attitudes and actions towards victim
- Lack of demonstrated remorse
- Lack of demonstrated empathy
- Integrity abuse towards the victim (e.g., denying facts) in context of treatment (couples)

What Should I Understand About the Victim's Experience in this Room?

The experience for the victim is that they just had a traumatic exposure to the secret sexual basement, they are experiencing the fragmentation of their PRE, in addition to attachment rupture, and they are laying on the road bleeding…and then they are subjected to further integrity abuse.

The victim is suffering from post-traumatic injuries from the car crash, in addition to additional harm by the abuser (driver) while they are both in a post-traumatic and injured state. This room shines the light on the driver – how they respond and act toward the victim at the time of exposure to the DCSR, when the victim is likely falling apart.

Further, during the exposure phase, the abuser may:

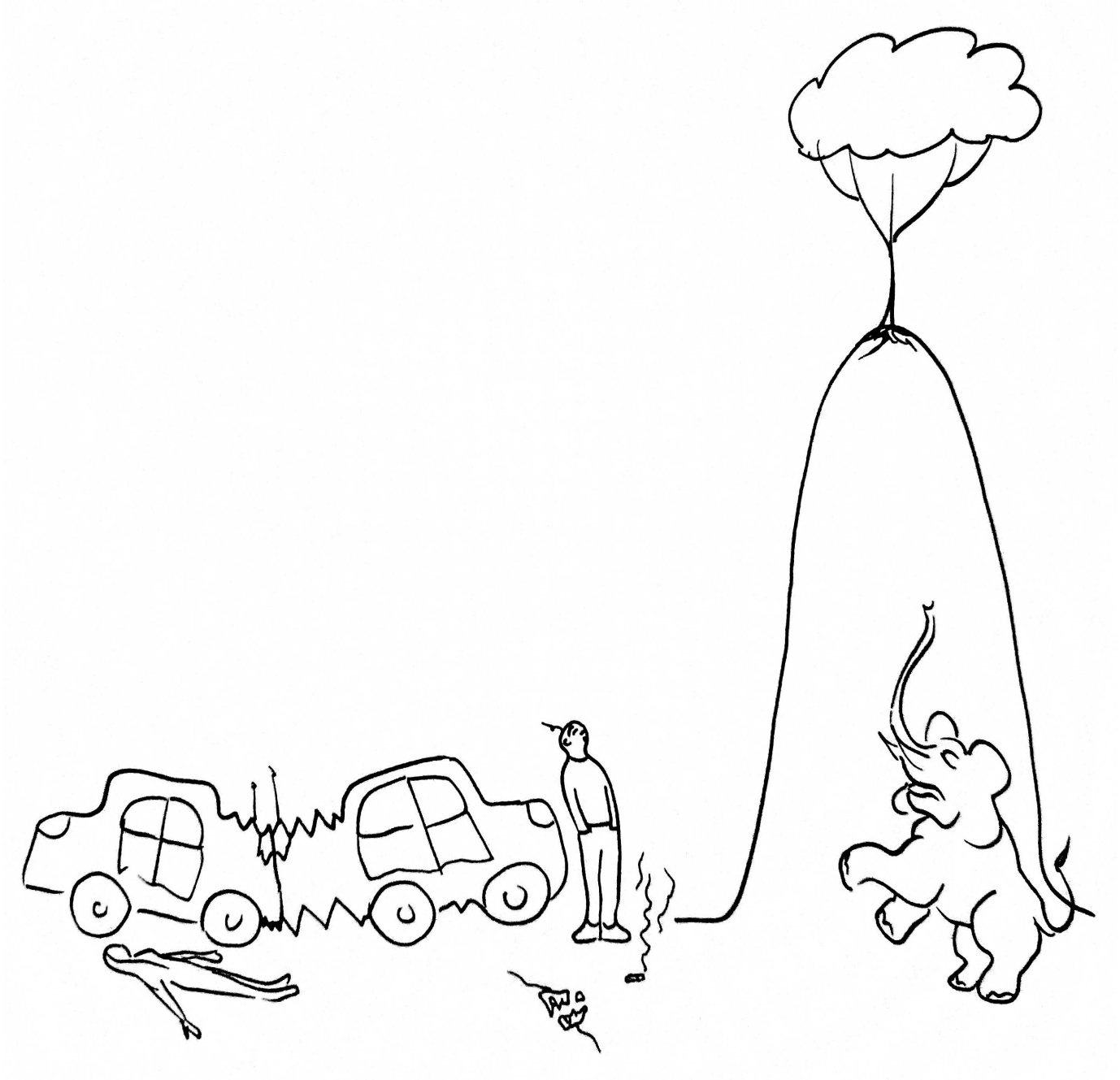
- Escalate the integrity abuse as they attempt to respond
- Use different tactics and defenses than they did in the covert phase, which are not familiar to the victim (e.g., acting very angry or threatening)

These new responses can make the victim feel like they no longer recognize the abuser (on top of not recognizing the type of person who would create and spend time in a secret sexual basement).

These are all important points to understand clearly when attempting to understand the victim's experience in this room. It is also important in helping the abuser, the victim(s), and the injured relationship(s) to be educated and facilitate metabolization toward healing.

Exposure Phase Integrity Abuse

This refers to the integrity abuse that occurs around and after the time when the two realties intersect. The pre-existing reality of the intimate partner shatters, collapses, or alters to such a degree that it is experienced as a reality fragmentation and a type of psychological traumatic loss. The abuser often may change tactics and the abuse may become more overt or the abuse may even escalate at the scene of the accident because the abuser is now caught, overwhelmed, and highly defensive (in survival mode in trying to protect the self). This can mean that the partner and relationship experiences increased integrity abuse right when they are in acute trauma – amid a traumatic event and in post-traumatic stress.



Educational Metaphor: "The driver of a car accident and crash gets out and lights up a cigarette".

Upon reality-ego fragmentation and acute relational rupture and attachment injury due to discovery of the secret sexual basement, what and how did further and continued integrity-abuse impact your partner?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

1. CA Exercise and Working Out: Exercising the Muscle of Communicating Authentically (CA)
2. Narrate in Writing Exercise: Write or journal the story of what happened here, what you did, for your own reflection and study.
3. Right Brain Exercise: Drawn this room as it exists in AVT-ER; this Specific Behavior; or Dynamic (no words and letters); honest right brain expression for self-metabolization (ISH)
4. Letter from Survivor to You as the Abuser Exercise: Journal or write out a narrative of your victim-survivor(s) expressing how this specific integrity-abuse behavior or dynamic would be expressed, as if you were in their shoes, writing a letter to you, in their voice, the best you can write it.
5. Gestalt Exercise: Step back now, reflect, and "Take in the "Whole" (Right Brain), Sit with; then take notes after sitting with, and meaning make, can sometimes sum up in a word or idea or concept, a condensation and distilled product of the psychological work and exercise.

WTF

Important: Always notice your thoughts, certainly must become aware of your emotions, and then particularly your responses and defenses, **and circle or identify those**, because those are your golden nuggets from your hard work, made more conscious for your continued metabolization, integration and growth.

What's Your Plan Man?

Important: Any Actions to Integrate to Your Work Plan and Practice?

Your Human/Masculine Safety-Net: If you can share and consult and receive IAR feedback and human input from and with your **Conscious Dignifying Circle**, (CDC), even better.

The Breath:

Organic powerful tool of human regulation; regulates all systems of the psychological spinal cord, all six vertebra and every moment. It is always there and available for you to grab onto and use. And it's free. Your organic life-preserver to learn how to use to stabilize, steady, slow down, stay still, sit with, and eventually be vibin.

Inhale IAR = Intentionally Accurate-Authentic Reality (Data, Information, Vibes)

Inhale IAR consciously to help you swim, surf, eat elephant, to metabolize and move through AVT-ER

Nobody is perfect…But every man can become a better man.

And never forgetting but learning to exist and live in a state and condition of remembrance, for the harm we have caused humanity, collectively, and hence we will always lead with a vibe of humility forevermore.

Room 5

Room 5: Discovery Trauma

Discovery trauma is not just the primary intersection of the PRE and DCSR being discovered by the victim, but the entire timeline and story of discovery events, each time causing some degree of destruction to the previously relied upon version of pre-existing reality.

Discovery Trauma

There are two processes by which the PRE intersects with the DCSR: discovery and disclosure.

Discovery refers to the person becoming aware or finding out about the existence of the DCSR.

Disclosure (which we'll see in the next room) represents a type of discovery in which the person is told about some aspect of the DCSR, most often (but not always) by the partner who has created and maintained the DCSR. Disclosure is a specific type of discovery and discovery process.

Discovery (and disclosure) often result in the injury of reality-ego fragmentation (REF), which will be discussed in detail in this room. Even though discoveries and disclosure are similar, they are also separated and distinct in terms of the traumatic experience and the traumatic story of the person. Hence, these rooms are connected and do often relate, yet they are also separated for the purposes of clinical treatment.

During the exposure phase, there are usually multiple discoveries and disclosures that occur around the same time, all causing different types of reality-ego fragmentation. In understanding survivors' experiences, it is important to distinguish between discovery and disclosure and to note that each is associated with its own, unique types of traumatic experience.

It may be easy to conceptualize discovery or disclosure as one big car crash, which it sometimes is. In fact, terms such as "D-day" may be used by victims or couples to represent the day that these two realities intersected and the day that the PRE was lost. However, it's more often the case that there is a long history of car crashes – with many separate discoveries and disclosures – that sometimes over decades.

What is Discovery Trauma?

- A discovery is when the victim finds out about the DCSR (true or false, it represents when the victim's psyche is exposed to the DCSR)
- When the PRE and DCSR meet, there is an intersection of two realities, which initiates a specific injury
- This injury is called reality-ego fragmentation (REF), which involves alterations to the PRE
- Each car crash (i.e., discovery) causes alterations (damage) to the PRE that was hit
- The context of the discovery is important:
  - **What** the victim discovers in the basement
  - **How** the victim discovers it
  - **When** the victim discovers it
  - **Where** the victim discovers it
  - **Who** built the basement and who is involved

Discovery Trauma

Discovery of a secret sexual basement is a critical traumatic incident (discovery incident) as well as an ongoing traumatic process (discovery trauma). The configuration of traumatic discovery experiences can vary (Steffens & Rennie, 2006). Discovery can be an initial awareness or a gradual development of consciousness, but is often a sudden and direct collision between the victim's pre-existing reality and the secret sexual basement. This collision may cause post-traumatic stress symptoms, which are often acute and progressive and can include shock and disbelief, a high degree of rage due specifically to the betrayal, extreme fear, hyper-vigilance, and trauma-based reactivity and survival responses.

The collision may also cause reality-ego fragmentation (REF), as structural and functional damage alters the victim's pre- existing reality. This destabilizing injury is threatening to the psyche and introduces fear into the psychological-relational system, including "flight," "freeze," or "flee" survival-based responses. The victim's pre-existing reality is altered from its original form forever, resulting in a psychological death experience. The shattering of the assumptive world by this betrayal can cause a grief response which includes traumatic grief, numerous secondary losses, and/or disenfranchised grief, which is any grief which is judged or minimized by others. Since no one has physically "died," the grief can seem ambiguous, and the loss may not be witnessed or recognized by others. Further, the betrayed may find themselves living with anticipatory grief – imagining the wreckage of their future – and grieving the potential loss of stability, relationship, etc. before such a physical or emotional separation has occurred.

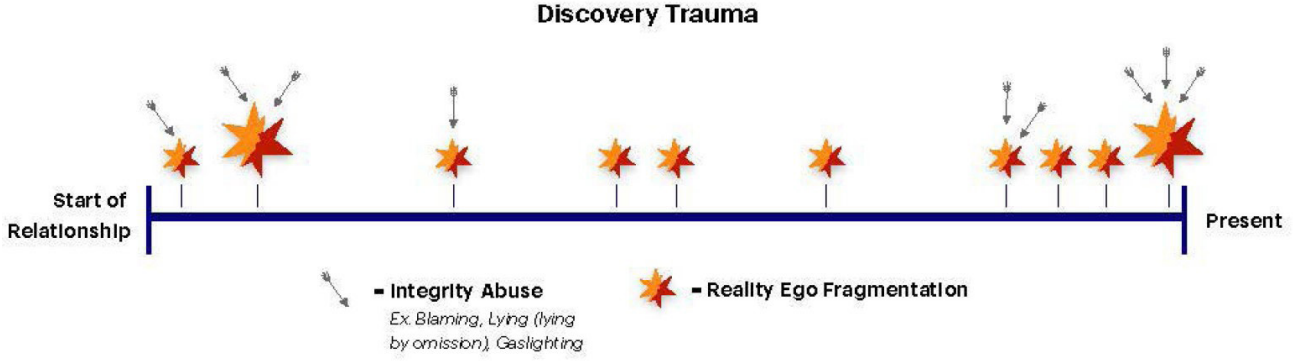
A discovery does not in any way indicate that the partner has the full and complete awareness, understanding, or truth of the secret sexual basement. Instead, a discovery means the victim's pre-existing reality has been injured and changed, resulting in some degree of awareness. This may lead to questioning about the secret sexual basement, including inquiries to the full extent and nature of the basement, how and why it was built, and who is the person who built it and has access to it. The answers to these questions inform decisions related to survival moving forward and impact the ability to provide sufficient stabilization.

The victim has no way of knowing or confirming the extent and nature of the secret sexual basement. The truth of reality has been systematically denied and withheld from them. Upon exposure, the abusive partner's word is revealed as corrupt and is no longer a reliable source of information, so even if they disclose the entire truth immediately with remorse, the victim will have no way of confirming it. The victim may wrestle with traumatic imagination and questioning, and truth-seeking will take time and require a process for the victim to fully comprehend. This delay in finding a grounding truth often provokes feelings of severe panic, terror, horror, and/or helplessness.

To fully understand the impact of discovery trauma, we must also consider the integrity abuse that may occur around each discovery incident. The abusive partner may utilize different tactics and defenses than those that have been used in the covert phase. Integrity-abuse behaviors may even escalate at the time of the discovery trauma because that is when the abuser's defenses and attempts to prevent further discovery are at their peaks. Integrity-abuse behaviors at this time may include stonewalling, denying, lying, technical manipulation, dictating and controlling the narrative, gaslighting, and getting angry or defensive. In response to these behaviors, victims may experience reality-ego fragmentation and an acute state of post-traumatic stress.

A victim often experiences multiple and various forms of discovery incidents and processes over time, sometimes over many years or decades. It is important to consider each discovery as a unique trauma-inducing event (Steffens & Rennie, 2006). To reduce the clinical conceptualization of discovery trauma to a singular traumatic episode is often diagnostically incomplete and dismissive of the reality and the experience of the victim. As with all traumatic incidents that are ongoing and repetitive, if there are many or frequent discovery episodes over time, then the discovery trauma may constitute a form of CTS of the victim, in addition to each event causing post-traumatic stress. Integrity abuse and reality-ego fragmentation may be experienced together and stored as one traumatic memory. How the abusive partner responds to the discovery, their responses and reactions towards the victim, and their treatment of the relationship during the exposure phase will impact the type and severity of the traumatic experience for the victim and the relationship.

Victims of discovery trauma within the exposure phase experience acute trauma in response to integrity abuse as well as ongoing trauma due to escalating or continued patterns of psychological, emotional, and relational abuse. It is essentially like "kicking someone when they're down," "adding insult to injury" and "putting salt on the victim's wounds." Abusing someone who is in the depth of traumatic experience and who has just experienced a psychological death increases injury to the victim and impacts their ability to heal.



Gestalt Metabolization Exercise

This exercise is helpful in understanding and appreciating the discovery experiences of a victim during the exposure phase. The exercise involves stepping back and looking at the whole timeline of the experience – as a whole story – and also taking in the details of each experience. As you go through the exercise, focus on stepping back, sitting with the information, taking it in emotionally and consciously (using your intentional mind, awareness of self, and internal reactions), and – over time – making meaning of it all (metabolizing the whole experience) to facilitate continued survival, growth, and health. **Stepping back and metabolizing the gestalt (which utilizes the right brain) is a key part of this exercise.**

- **Step 1:** Create a timeline and place all discoveries (car crashes) on the victim's timeline
- **Step 2:** Onto the timeline, add the 1 to 4 most relevant integrity-abuse behaviors (arrows) experienced by the victim around the time of each discovery; notice your thoughts and feelings and share the process with others

Remember: There is no right or wrong in what emerges here. Allow the process to remain organic and natural, because it is, while still adhering to the structure, method, and purpose of the exercise.

Group Exercise

This exercise involves sharing discovery trauma timelines to allow for deeper metabolization or ownership, shame-reduction, and learning from other people's experiences. Through this exercise, victims may have the opportunity to engage in post-traumatic survival, healthy coping, and healing.

- **Step 1:** Share and discuss timelines with others in a group setting
- **Step 2:** Notice your thoughts and feelings as you share and learn – take notes and process with others

Remember: There is no right or wrong in what emerges for you. Allow the process to remain organic and natural, while still adhering to the structure, method, and purpose of the exercise.

Discovery Trauma

Discovery trauma describes the experience, or the many experiences over time, of discovering some aspect of the DCSR, resulting in reality-ego fragmentation (attachment ruptures and injuries). This also includes all the abusive or harmful experiences (IAD) that occur around these discovery events (e.g., stonewalling, denying, and lying, gaslighting, getting angry or defensive versus taking responsibility and having remorse or empathy, blaming the partner or the relationship, etc.).

Mechanical Description of Discovery Trauma:

Discovery (Disclosure) is the victim's psyche being exposed to the DCSR (when the victim's PRE intersects (big or small "car crash") with the DCSR (true or false) Discoveries are separated in a different room from disclosures, as a separate traumatic process. So, make sure to only focus cleanly on ***discoveries here.***

A discovery is ***when the victim finds out about the DCSR*** (true or false, it is still an exposure to the victim's psyche to a DCSR) It also ***what*** the victim discovers in the basement or about it, ***how*** the victim discovers, or if the victim discovers, ***when***, and ***where*** the victim discovers and ***who*** built and is involved in it

Specific Injury: Reality-ego Fragmentation (REF) in combination with IA (Integrity-Abuse)

1. When these two realities touch, the PRE and the DCSR, there is an intersection of two realities, which initiates a specific injury
2. This injury is called Reality-Ego Fragmentation (REF), which are the alterations to the PRE
3. Each car crash causes damage or alterations to the PRE that gets hit
4. The metaphors of a car crash, or a drop of ink in clear glass of water, both describe REF
5. Ink in water – shows how the entire reality is "tainted" now
6. Another metaphor is that every file in the computer is corrupted by a virus - so no previous memory is the same – it is now alerted – with this new information – "the drop of colored ink" so this causes a loss of years of reality
7. Discovery (and Disclosure) are the only ways to cause REF, so these three, have a relationship; discoveries and disclosures cause REF
8. The more years or time of investment can impact the traumatic loss of the PRE

Disclosure Trauma Exists on a Timeline (a Story not just an Event):

1. Sometimes people talk of D-day – which means the beginning of the exposure phase, and often referring to when the victim finds out about the secret sexual basement; the acutely traumatic serious injury of the PRE and DCSR intersection (car crash)
2. It is important however, not to reduce many car crashes to just one accident, if there are more than one (that is minimizing and not the truth)

Mechanical Description and Data:

1. The way to understand this injury is to create a timeline and place all disclosures, not discoveries, but only disclosures, on the victim's timeline
2. In Room 4 we discussed the driver of a car accident – abusing the victim on the road bleeding – with integrity-abuse – making the whole scene way worse in terms of harm
3. On the timeline, it is also important to describe what integrity-abuse behaviors happened to the victim on the road, surrounding the disclosure or associated with the disclosure
4. So, the timeline should include all the disclosures (car crashes) on a timeline, along with the associated Integrity-abuse that occurred with each one (the arrows)

Gestalt Metabolization Exercise(s):

5. This is the proper way to understand and appreciate what happened to this person
6. This involves stepping back and looking at the whole timeline; as a whole story (as well as also taking in the details of each experience)
7. This stepping back and taking a look, is the point here – and sitting with it – which means to allows and permit – metabolizing – which means taking it in emotionally as well, and consciously (using your intentional mind and awareness of self and internal reactions); and thus over time "making meaning" (the nourishment being received similar to why we eat (metabolize), to get nutrients to facilitate continued survival, growth and to optimize health
8. ***Stepping back and metabolizing the gestalt, is part of the point in this exercise. (this utilizes the right brain)***

Group Exercises:

1. Discussing and sharing timelines in a group allows for additional metabolization; It allows others to learn from seeing each other's timelines.
2. Again, notice your thoughts and your feelings with these exercises and in this room – as you metabolize, take notes and process with others.

What is your partner's discovery story related to the secret sexual basement?

How has that story impacted you?

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Can you lift up, and get out, and express this story?

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Room 6

Room 6: Disclosure Trauma

Disclosure trauma is not just the primary intersection of the PRE and DCSR being discovered by the victim, but the entire timeline and story of disclosure events, each time causing some degree of destruction to the previously relied upon version of pre-existing reality.

Disclosure Trauma

What is Disclosure Trauma?

- A disclosure is **what the victim is told (often by the abuser) about the DCSR** (true or false, it represents when the victim's psyche is exposed to the DCSR)
- The context of the disclosure is important:
  - If the victim is told
  - How the victim is told
  - When the victim is told
  - Where the victim is told
  - By whom the victim is told

Disclosure Trauma. Disclosure is a specific type of discovery (Steffens & Rennie, 2006). A disclosure experience refers to incidents or processes, sometimes occurring over many years or decades, wherein the victim is told about some aspect of the DCSR (the secret sexual basement). The intersection of the victim's pre-existing reality (PRE) with the DCSR can lead to disclosure incidents and disclosure trauma. As with discovery, a victim will typically experience multiple disclosure events that are often delivered in harmful or abusive ways (e.g., angry disclosures, partial disclosures framed as full disclosures, staggered disclosures, resisting and refusing disclosures, defensive stalling, etc.).

Each disclosure incident has the potential to become a specific traumatic event, leading to traumatic reactions and processes that may last for many years. Disclosures can lead to sudden and extreme ego disintegration, and/or they can cause a subtle, slow dissolution of ego structures. It is important to assess and to understand how many disclosures have occurred over time and understand the experience as a series of traumatic exposures to integrity-abuse behaviors for the abuse victim.

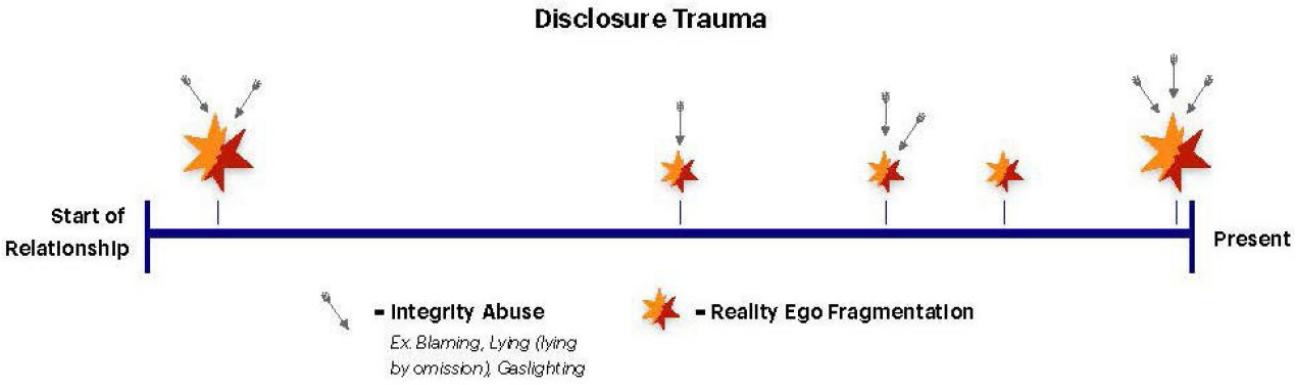
An Important Story: Integrity Abuse and the Disclosure Process for the Intimate Partner

Each victim has a unique story to tell about their disclosure process. Each victim was told a unique story during their disclosure process. Some victims were told they did not deserve to know the truth. Some were stonewalled, ridiculed for asking for information, and asked to move on without knowing. Even various treatment models and approaches discount the need for victims to get complete honesty, accuracy, and truth to make informed and healthy decisions moving forward about their reality, now that they realize they have been subjected to a system of misinformation and deceptive manipulation, sometimes for years. The abuser or the abuser's therapy may not support disclosures and may sometimes collude with the abuse by encouraging the abuser not to disclosure anything and to continue to hide the truth from the intimate partner.

Some harmful potential experiences that some people may experience associated with the disclosure process include:

- The victim is intentionally prevented from knowing the truth
- The victim is treated as if they do not deserve the truth about their own reality
- The victim is ridiculed or demeaned for asking for more information
- The victim's need for the truth (to move on and progress with healing) is misunderstood or minimized
- The victim is seen as not having the right to know the truth of how they are being covertly abused and harmed
- The abuser does not provide the truth in a timely manner, due to negligence
- Inaccurate disclosure; More lies, dishonesty, and manipulation while disclosing
- Disclosing with rage, anger, frustration, and/or a callous attitude versus with remorse, empathy, and sincerity
- Partial disclosures or false disclosures framed as the truth (e.g., looking into the victim's eyes and swearing they have told the victim everything)
- Staggered disclosures versus the whole truth at one time, within a context of safety and care

Note that treatment can be part of what obstructs, unnecessarily delays, or prevents full disclosure.



Gestalt Metabolization Exercise

This exercise is helpful in understanding and appreciating the disclosure experiences of a victim during the exposure phase. The exercise involves stepping back and looking at the whole timeline of the experience – as a whole story – and also taking in the details of each experience. As you go through the exercise, focus on stepping back, sitting with the information, taking it in emotionally and consciously (using your intentional mind, awareness of self, and internal reactions), and – over time – making meaning of it all (metabolizing the whole experience)
to facilitate continued survival, growth, and health.
Stepping back and metabolizing the gestalt (which utilizes the right brain) is a key part of this exercise.

- **Step 1:** Create a timeline and place all disclosures (car crashes) on the victim's timeline
- **Step 2:** Onto the timeline, add the 1 to 4 most relevant integrity-abuse behaviors (arrows) experienced by the victim around the time of each disclosure - notice your thoughts and feelings and share the process with others

Remember: There is no right or wrong in what emerges here. Allow the process to remain organic and natural, because it is, while still adhering to the structure, method, and purpose of the exercise.

Group Exercise

This exercise involves sharing disclosure trauma timelines to allow for deeper metabolization or ownership, shame-reduction, and learning from other people's experiences. Through this exercise, victims may have the opportunity to engage in posttraumatic survival, healthy coping, and healing.

- **Step 1:** Share and discuss timelines with others in a group setting
- **Step 2:** Notice your thoughts and feelings as you share and learn – take notes and process with others

Remember: There is no right or wrong in what emerges for you. Allow the process to remain organic and natural, while still adhering to the structure, method, and purpose of the exercise.

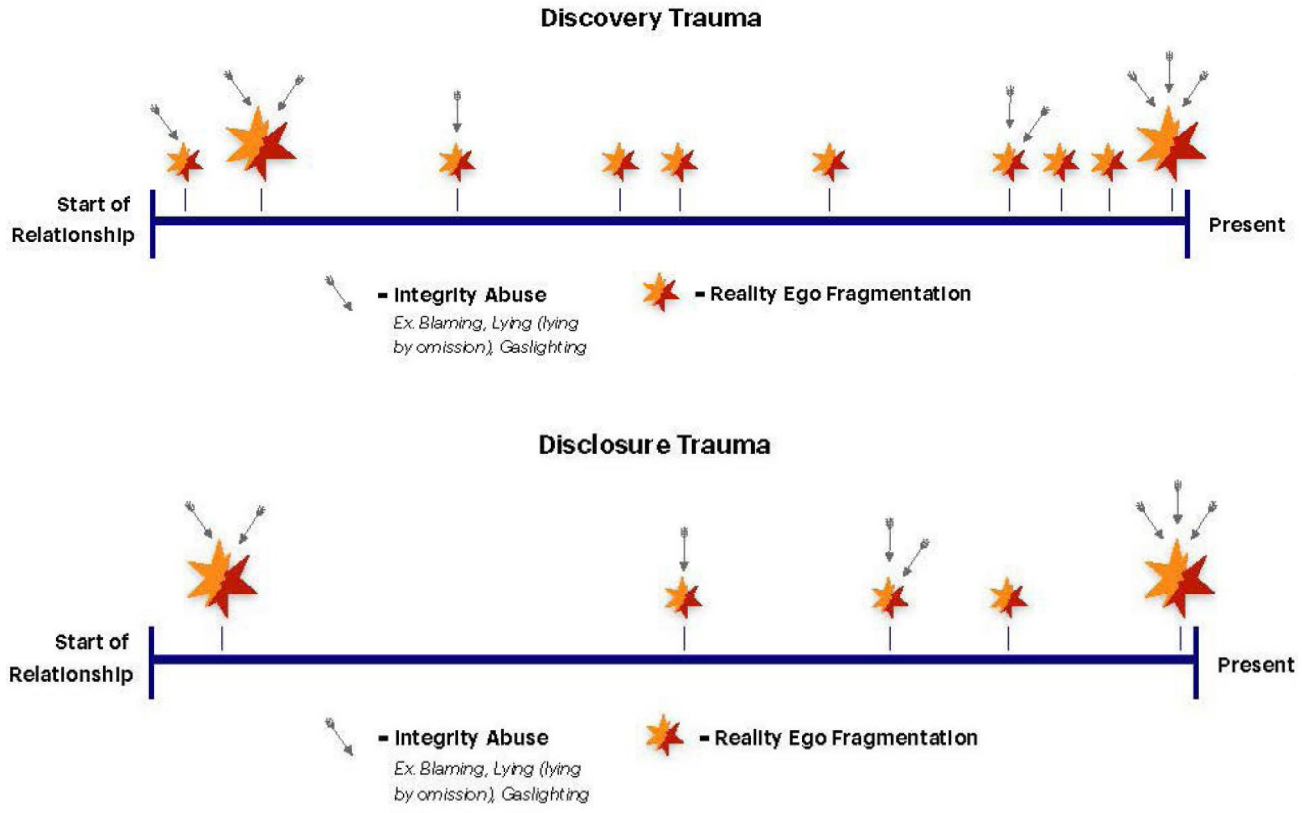
Important to Remember:

It is important not to reduce the experiences in Rooms 5 and 6 to just reality-ego fragmentation (REF) or attachment injury. Remember what we learned in Room 4 – that there are often integrity-abuse behaviors occurring concurrently with discoveries and disclosures. The person undergoing post-traumatic stress fragmentation is subjugated to additional harm and abuse while injured and in a state of acute stress.

Metaphors to Represent REF

- Car crash
- Drop of ink in clear glass of water (shows how the entire reality is "tainted" now)
- Virus causing all files in the computer to be corrupted, so no previous memory is the same

Understanding and Making Meaning of Both the Discovery and Disclosure Trauma Timelines



Taking in the gestalt and stepping back to make meaning of both the discovery and disclosure trauma timelines together can also be important and helpful in understanding the victim and exactly what they have experienced. Questions that can be asked as the timelines are reviewed include:

- How many car crashes has this person been in as the victim?
- When were these over the years of time?
- When was the last car crash?
- What are some of the main integrity-abuse behaviors the person experienced when on the ground bleeding?
- Who exposed the victim to integrity-abuse behaviors (the driver, the treatment provider, etc.)?
- What patterns, if any, are there?
- Do disclosures tend to appear after discoveries?
- If there are a lot of car crashes and/or the same type of integrity abuse during those car crashes, consider the presence of complex trauma shaping over time

Disclosure Trauma

Disclosure trauma describes the experience, or the many experiences over time, of a disclosure (i.e., being told about some aspect of the DCSR), resulting in reality-ego fragmentation. This also includes all the abusive or harmful experiences (IAD) that occur around these disclosure events (e.g., disclosing in anger, sadistic disclosures, partial disclosures framed as full disclosures, staggered disclosures, resisting and refusing disclosure, defensive stalling, etc.).

A disclosure is **what the victim is told (often by the abuser) about the DCSR** (true or false, it represents when the victim's psyche is exposed to the DCSR)

Disclosure Trauma Exists on a Timeline (a Story not just an Event):

1. Sometimes people talk of D-day – which means the beginning of the exposure phase, and often referring to when the victim finds out about the secret sexual basement; the acutely traumatic serious injury of the PRE and DCSR intersection (car crash)
2. It is important however, not to reduce many car crashes to just one accident, if there are more than one (that is minimizing and not the truth)

Stage 2:

1. What occurred to your partner in this room? (Human Voice, Initial Expression)
2. What occurred to your partner in this room, your partner's disclosure trauma story? Human Voice, Narrative Written/Recorded
3. Mechanical Disclosure Trauma Timeline
4. Gestalt of Mechanical Disclosure Trauma Timeline
5. What would you state as your partner's three most serious or difficult experiences, injuries or symptoms, specifically, and then describe?
6. What is currently your partner's most relevant concern(s) (if any) related to this room?
7. Any ways to reduce distress or impairment, for your partner related to this room?
8. Any specific goals?
9. Any specific tools, interventions, ways to facilitate health-promoting progression towards goals specified?
10. In a sentence: State your partner's truth in this room right now.

Stage 3:

1. DST-Stage 3 Metabolization of Victim-Survivor Story: Eating Elephant (Human Voice) in proper DST-Conditions, Context, Care
2. DST-Stage 3 Metabolization of Victim-Survivor Story: Eating Elephant (Human Narrative Written/Recorded/Video) in proper DST-Conditions, Context, Care
3. Right Brain Exercise (Draw): Disclosure Trauma
4. Share and use voice to tell AVT-disclosure story and reality with the Mechanical Diagram: Externalize, Impose, Contextualize (Group Gestalt)
5. Reflect, Hold, Honor the Mechanical Diagram(s): Externalize, Impose, Contextualize with AVT-story and reality (Group/Silence)
6. Somatic Integration
7. Final Exercise: Both timelines; stabilized and described, and then metabolized, including gestalt

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Room 7

Room 7: Reality-ego Fragmentation (REF)

Upon a discovery or disclosure, the pre-existing reality and internal reality (ego) being subjected to the DCSR, causing permanent alterations to the original form(s) of pre-existing reality.

Reality-ego Fragmentation (REF)

Reality-ego fragmentation (REF) occurs when the PRE intersects with the DCSR. REF refers to psychological alterations that include a shattering of the ego (i.e., the self) and/or the inner reality. Within this clinical model, the term ego describes our subjective sense of ourselves – the aspect of experience that we describe as "me" or "I." Reality is defined as our subjective experience of everything in totality. Thus, the term reality-ego refers to our entire sense of everything, our entire reality, including our sense of ourselves. Our ability to accurately perceive and effectively adapt to reality is essential for psychological health and stability.

The ego serves as a protective boundary between oneself and one's environment. When two separate realities collide (as is the case in the exposure phase), the result is a process of de-structuring reality and progressively transforming the PRE. As someone goes through this process, their subjective experience of everything in their world is de-structured and transformed. It's like waking up one day and feeling like a totally different person, with a completely new identity (Jason & Minwalla, 2009). This process tends to be destabilizing, to say the least, and can lead to serious psychological injury. In fact, the reality-ego is itself traumatized and immediately or eventually fragmented. The injury to reality can lead people to feel weakened, shattered, and broken. Many people report feeling like their whole relationship has been a lie or a sham.

REF is often experienced as a sudden "psychological death," a serious threat, or a significant injury that leads to post-traumatic symptoms. REF may be conceptualized as a psychic death because the victim's global sense of reality, including their reality of themselves, is substantially fragmented and damaged by the exposure to the DCSR. The person's PRE is essentially lost forever. It can never be reconstructed to exactly match how it existed before the intersection. Although it may be possible to repair, recover, and heal, the original PRE will never exist as it did before colliding with the DCSR. It is important to recognize the significant grieving process that comes along with this type of expansive psychological loss.

Specific Injury: Psychological Death

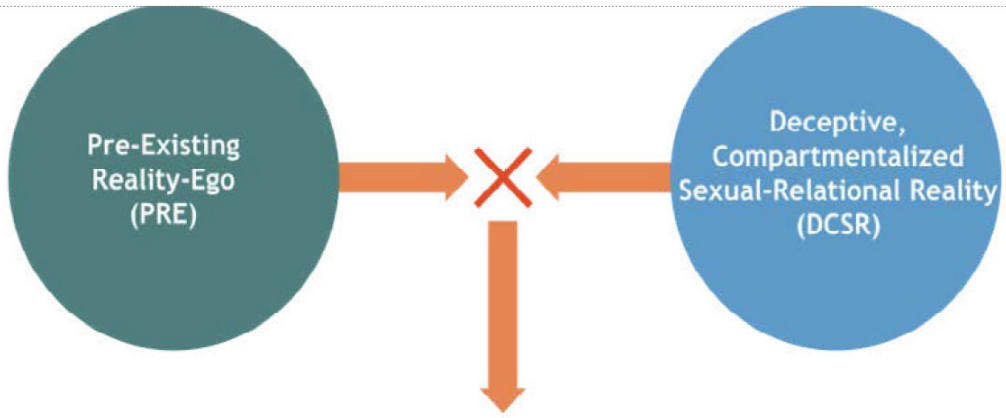
- The victim's PRE died – it is gone forever and never able to return to the exact original form
- The abuser's covert phase has also died
- The abuser may also experience REF – this means they also experience a shattering of their ego or "who they thought they were" (which is why mountain work is so healing for the abuser)
- The relationship in its original form and function is also now dead
- A grief and mourning process ensues
- It cannot be about "getting back to where we were or used to be" – it must be about reconstructing something new and different
- Many people impacted by REF need conscious help and support with this type of grieving

Symptoms

- Primal grief and loss process (e.g., mourning, disenfranchised grief, etc.)
- Fear, rage, reactivity
- Primal survival: Fight, freeze, flee

People experiencing REF often describe the injury as a global type of experience (not a localized wound) and often use words such as tsunami, earthquake, hurricane, and shattering to describe their experience.

Reality-ego Fragmentation (REF)

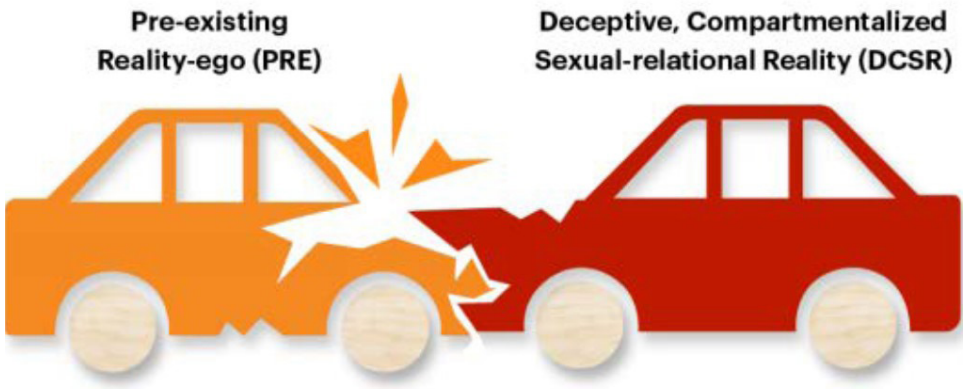


Critical Injury: Reality-Ego Fragmentation

Induction-Injuries:

1. Induction of Fear into System
2. Survival Coping and Defenses
3. Injury and Loss, Loss of Self, Relationship, Family and Reality

Critical Injury: Reality-ego Fragmentation (REF)



Reality-ego Fragmentation

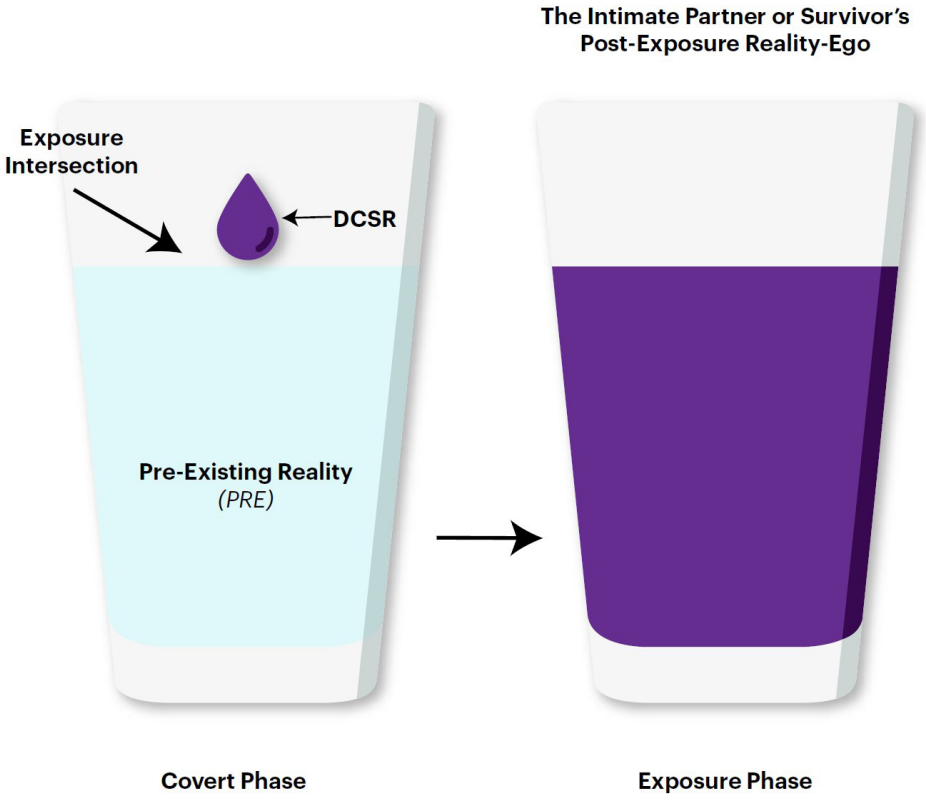
Post-traumatic Stress Symptoms:

- Hypervigilance, Intrusions, and Persistent Re-experiencing
- Avoidance of Trauma-related Stimuli
- Negative Alterations in Thoughts and Mood
- Trauma-related Arousal and Reactivity
- Distress and Functional Impairment
- Dissociative Symptoms

Remember that REF tends to cooccur with integrity-abuse behaviors and conditions (often escalating at this time), so victims are exposed to even further, more devastating integrity abuse when their REF is most acute and painful.

Reality-ego Fragmentation (REF)

Entire reality has been tainted by the truth of the Secret Sexual Life, like a drop of ink in a glass of water



REF exists as a process called the Exposure Phase (it's a story not just an event)

- The PRE and the DCSR are two separate realities until they are exposed to each other, which can be a single event (think car crash or colored ink in water) and or a process of many events unfolding over time.
- The victim's psyche also continues to be exposed to aspects of the secret sexual basement, getting a more detailed conceptualization of what the basement is/was all about (i.e., the nature and extent of the sexual or relational activities and dynamics), the integrity-abuse behaviors, how the systemic deception worked, and what was the modus operandi behind it.
- The victim(s) psyche wonders Why? And how could they be deceived? And then how could the abuser, who is most often someone's intimate partner they thought they knew and loved deeply, be so cruel, split, and dehumanizing? (this is where the victim metabolizes the sociopathic aspects).
- So, understanding the car crash and the secret sexual basement is a process of exposure, where two realities crash and then need to fuse and meld into one reality for the victim.
- This process of melding continues into the symptom progression phase as well.

Exposure Phase Injury Cluster: Reality-ego Fragmentation (REF) + Attachment Rupture + Integrity Abuse (IA)

It is important to not conceptualize the exposure phase as REF – it should be thought of as an exposure phase injury cluster. While REF is one source of trauma in this phase, attachment rupture (Room 8) is an equal (or sometimes larger) source of acute distress and post-traumatic stress. Further, we must add the integrity abuse that often cooccurs with these two sources of trauma.

An Educational Metaphor: "Ink in Water"

While the sudden and global loss of the PRE is often described as a car crash, it can also be a slow, unraveling process – like a drop of colored ink in a clear glass of water. The drop of colored ink in water can be used as an educational metaphor to understand reality-ego fragmentation (particularly as a total versus local injury) and to also better appreciate when victims say, "It seems like everything in this relationship has been a lie" (a statement which may be argued against by the abuser).

In this educational metaphor:

- The PRE is a clear glass of water
- The DCSR is a drop of colored ink
- The mechanics of this REF injury require the intersection of the PRE with the DCSR, causing alterations to the PRE (a death of the original form)
- When the drop of colored ink touches the water, the surface is the intersection point
- The result is that the entire glass is now a different (tainted) color (REF) and there is no way of protecting the clear part of the water – it is like every memory in the victim's brain related to the relationship and this person has been tainted and changed

Reality-Ego Fragmentation

This critical injury is reality-ego fragmentation (REF), which occurs after the intersection between the victim's PRE and the DSCR (during the exposure phase). The injury consists of damage and alterations to the person's PRE, which results in PTSD-related symptoms.

Describe your partner's experience of reality-ego fragmentation (REF).

Can you describe your partner's pre-existing reality (PRE) and the current reality?

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Room 8

Room 8: Acute Relational Rupture and Attachment Injury

Upon a discovery or disclosure, the pre-existing reality of the intimate partner and relationship causes a relational rupture which causes significant attachment injury.

Acute Relational Rupture and Attachment Injury

Healthy and secure attachment to human beings is essential for psychological health. An attachment relationship is like a "psychological safety net to catch us if needed". When faced with life-threatening events, we typically seek our attachment partner for support as a survival instinct. On the other hand, disconnection from significant others often results in pain, dysregulation, and disease. When attachments are destroyed, the primal sense of safety and protection that had come from the attachments are lost (Johnson, 1996).

During the exposure phase, the rupture from what may have been previously experienced as a secure attachment, which included some level of psychological and emotional dependency, represents another critical traumatic injury. Because of the exposure to the DCSR, the person that the victim thought they knew and thought they could depend on is no longer there. This represents a sudden loss of the psychological safety net and causes a significant fall with no cushion. This type of relational rupture and attachment injury can lead to an inability to re-establish healthy or even regulatory attachments (Johnson, 1996) which, in turn, can result in dysfunctional reactions and an eventual loss of relational stability and basic dependency.

The type of behavior that the abuser engages in influences the specific impacts on the attachment relationship. But the attachment relationship is also harmed by just the simple fact that the person's psyche alters from safe and secure belief systems related specifically to trust, reliance, and survival dependency to the realization of the potential for threat to that very precious and stabilizing system of basic relational assumptions. These systemic assumptions and belief systems built within the psyche related to the safety net and the go-to person can be altered with just the slightest detection of sexual-relational threat, indicating a vulnerability that never existed before to that which seemed strong, secure, and safe.

The attachment injury associated with the exposure phase clearly impacts the partner or spouse, but it often also profoundly impacts the relationship as a separate, third entity. In other words, the relationship itself – the "us" is traumatized. This type of relational trauma, relational rupture in attachment often causes significant symptoms and defensive coping adaptations in both partners. The significant instability in each person, and between each person, is a source of trauma, as are the numerous failed attempts at re-attachment. All of this causes notable injury to dependency and trust, further detachment, and, eventually, a form of complex trauma that continues to erode the relationship.

What is an Attachment Relationship?

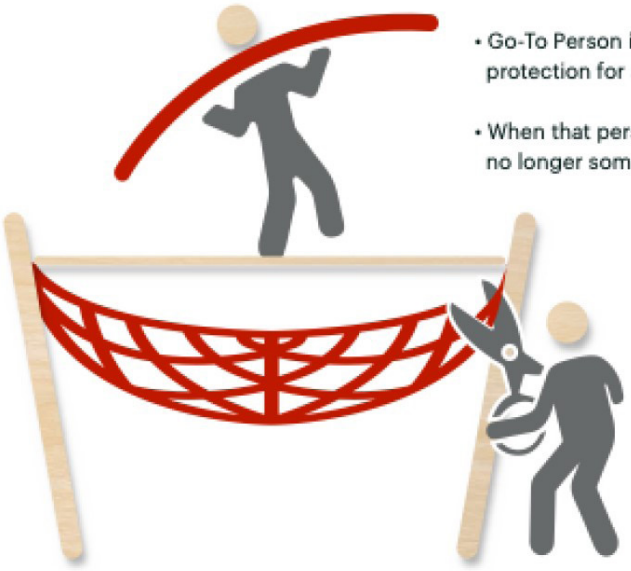
- An attachment relationship (Johnson, 1996) is a specific type of relationship where the other person is designated as a "go-to" person and part of the person's "psychological safety net"
- When faced with life-threatening events – or crises – we typically seek our attachment partner for support as a survival instinct
- The ASSUMPTION is that you have a safety net and a go-to person that provides stability for the psyche
- Attachment relationships involve a progressive investment in this ASSUMPTION
- The shattering of this basic assumption (Johnson, 1996) causes trauma, loss, and pain
- When attachments are destroyed, the primal sense of safety and protection that had come from the attachments are lost (Johnson, 1996); the psyche is no longer operating with this assumption, as it did before the loss

Attachment Rupture and Attachment Injury After Exposure to the DSCSR

- During the exposure phase, the rupture from what may have been previously experienced as a secure attachment – or at least the pre-existing assumptions that the psyche relied upon – which included some level of psychological and emotional dependency, represents another critical traumatic injury
- Because of the exposure to the DCSR, the person that the victim thought they knew and thought they could depend on is no longer there
- The loss of the PRE becomes an acute "life or death" experience
- In addition to losing their go-to person and not being caught when the net was cut, the victim also realizes that this person is actually the one who cut the net – the one who created the DCSR that just crashed into the PRE
- As such, the victim experiences two injuries: 1) the loss of being able to depend on being supported by the safety net and 2) realizing that the previous go-to person is now a threatening person from which the psyche needs protection (this is an important psychological experience to recognize and keep in awareness in treatment)
- Remember: The victim's pre-existing reality-ego (PRE) causes PTSD-related symptoms, but so does the attachment injury, so there are 2 separate (but related) sources of PTSD occurring at the same time here
- It is also critical to consider the integrity-abuse behaviors that the abuser often engages in upon the attachment rupture – these integrity-abuse behaviors at the scene of the safety-net injury will likely only serve to increase the damage to the victim and their injuries related to the attachment and trust

Post-exposure Attachment Injury and Relational Losses

Safety Net and Go-To Person

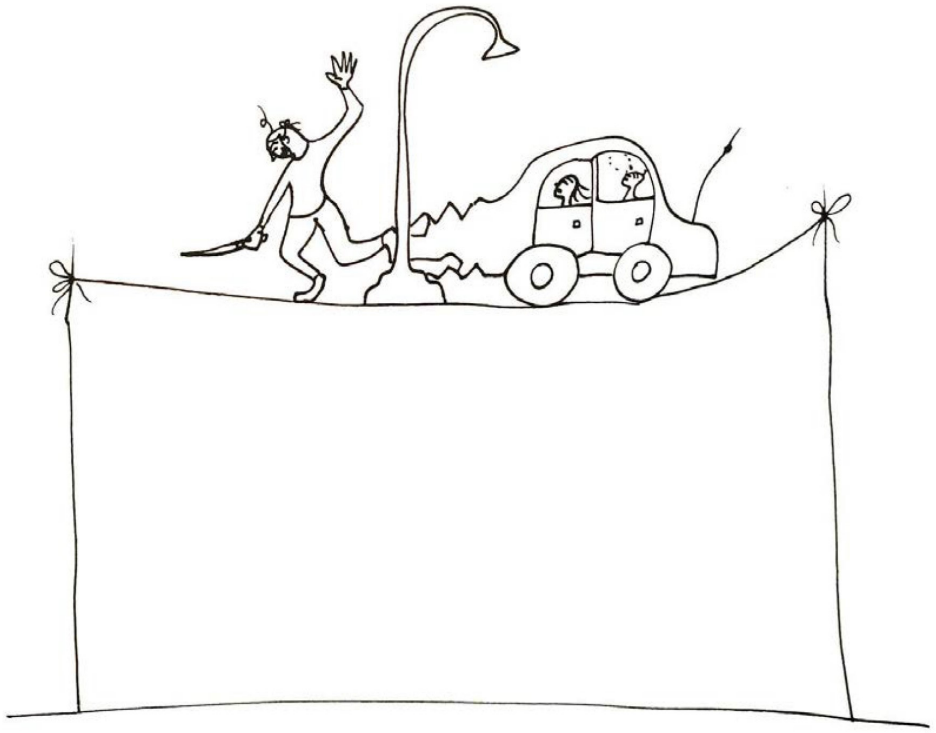


Go-To Person is lost

- Go-To Person is the person to lean on for help, support, and protection for survival and/or during times of crisis
- When that person cuts the safety net, they become a threat and no longer someone to go to for help, support, and protection

Safety Net is lost

- The Safety Net represents the psychological assumption of reliance and dependability during times of crisis
- The Safety Net is psychologically stabilizing
- The Safety Net is lost when the intimate partner discovers the DCSR



Educational Metaphor for Attachment Injury

- The safety net is lost, and the person hits the ground
- The go-to person is lost – no longer someone to turn towards or lean on
- The go-to person is actually the one who cut the net – they morph into a threat and become someone to defend against

Important Notice:
It's important to understand that even just the threat of sexual-relational infidelity is itself potentially threatening to attachment. Just the discovery of a "tiny secret text" can alter the assumption system of attachment related to trust of fidelity. A specific type of threat – a sexual-relational threat – is a potentially highly threatening type of threat because it targets the sexual-relational and intimate dimensions of the psyche, along with the person's reality and life. Hence, the partner may be walking on the tightrope of sexual-relational life and feeling stabilized by a secure safety net and go-to person, when they start to feel the slightest tremor or shake. This tremor or shake then causes significant instability and harm in the psyche and the attachment relationship.

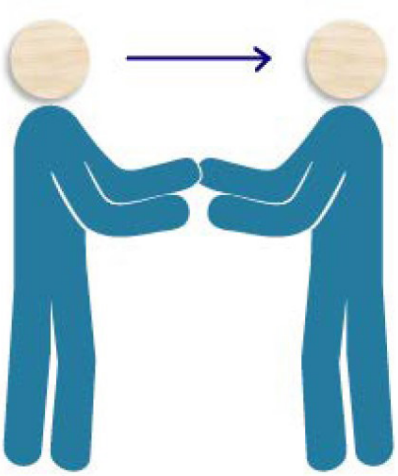
Conflictual Survival Instincts

As noted above, during this process the person's previous protector – their go-to person – has become a threat. In other words, the abuser is the perpetrator and the threat from which the victim needs protection. So, rather than instinctually turning toward that person, there is now a conflicting instinct to guard and protect against this abuser. These opposing instincts cause significant relational dysregulation, and the relationship becomes a trigger for each person within it. The victim often becomes terrified of the perpetrator. In addition, the abuser, who possibly also lost their PRE, their sense of attachment, and their psychological safety net, may also become fearful and triggered by the victim and the relational trauma. This can create a back-and-forth pattern of traumatic experience and seeking help from one's partner, followed by attempts to escape and separate from each other.

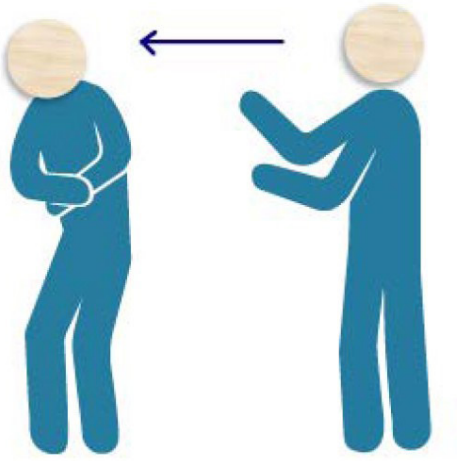
Attachment Injury Often Impacts the Victim, the Abuser, and the Relationship

- The attachment injury associated with the exposure phase clearly impacts the victim, but it often also impacts the abuser as well as the relationship as a separate, third entity
- This is because each person in an attachment relationship has their own unique reliance needs, safety net functions, instincts to turn towards, and assumptions about feeling safe and secure, etc.
- When the attachment stability is suddenly shattered and gone, then the psyche will be destabilized
- In other words, the relationship itself – the "us" – is traumatized
- This type of relational trauma often causes significant symptoms and defensive coping adaptations in both partners
- The significant instability in each person, and between each person, is a source of trauma, as are the numerous failed attempts at re-attachment
- All of this causes notable injury to dependency and trust, further detachment, and, eventually, a form of complex trauma that may continue to erode and alter the pre-existing relationship (persistent negative relational patterns in the symptom progression phase)

Conflictual Survival Instincts



Survival instinct in attachment relationship is to turn toward the "go to person" when needed in time of crisis or survival



Survival instinct when threatened, abused ot harmed is to defend, protect, guard against; not turn towards but stay away

Exposure Phase Injury Cluster:
Reality-ego Fragmentation (REF) + Attachment Rupture + Integrity Abuse (IA)

It is important to not conceptualize the exposure phase as just attachment injury – it should be thought of as an exposure phase injury cluster. While attachment injury is one source of trauma in this phase, the reality-ego fragmentation is an equal (or sometimes larger) source of acute distress and posttraumatic stress. Further, we must add the integrity abuse that often cooccurs with these two sources of trauma.

Be Mindful:

Relational repair attempts basically ask the victim to try to build a new assumption of the go-to person – the same person who cut the net and made them fall and hit the ground. As such, there tends to be a high level of vulnerability in relational healing attempts, which we must try to always be mindful of.

Questions to Consider

- How might a person start investing in a new safety net-building process, post-deceptive sexuality trauma?
- What is needed to develop and strengthen the assumption that the partner "has my back, and if and when I fall, they will be there to catch me…and certainly they won't cut the net once again"?

According to Warach and Josephs (2019):

- Research suggests that infidelity is highly detrimental to relationship longevity and to the well-being of betrayed partners
- Some authors characterize infidelity as a trauma that has the potential to constitute an attachment injury
- Findings suggest that infidelity-based attachment trauma manifestations may resemble disorganized attachment behavior
- The authors suggest a refined adjustment disorder diagnostic sub-categorization for people with infidelity-based attachment trauma

According to Falconer and Humphreys (2019):

- Limited research has investigated if sexting is considered infidelity
- In Falconer and Humphrey's study, seventy-five percent of university students that sexted secondary partners considered this act cheating
- Thirty-six percent also engaged in in-person sexual activity with the secondary partners they sexted

According to Zitzman and Butler (2009):

- Evidence is growing that pornography use can negatively impact attachment trust in the adult pair-bond relationship
- The aim of Zitzman and Butler's study was to understand the attachment implications of a partner's pornography use and concomitant deception
- Analyses uncovered three attachment-related impacts from husbands' pornography use and deception: the development of an attachment fault line in the relationship, stemming from perceived attachment infidelity, followed by a widening attachment rift arising from wives' sense of distance and disconnection from their husbands, culminating in attachment estrangement from a sense of being emotionally and psychologically unsafe in the relationship
- The wives in this study reported global mistrust indicative of attachment breakdown
- The authors propose an attachment-informed model of effects of pornography use and concomitant deception in the pair-bond relationship

Exposure Phase Post-abuse and Trauma Symptoms Waiting Room

This section of the exposure phase ward is dedicated to the focused assessment, understanding, and treatment of the symptoms from the exposure phase post-abuse and trauma symptoms section. The symptoms here relate to the following types of symptoms:

- Acute stress disorder
- Post-traumatic stress disorder
- Reality-ego fragmentation (REF)
- Attachment threat, rupture, and destabilization
- Betrayal trauma symptoms, spiking in anger and rage due to deceptive betrayal
- Traumatic grief and loss (an unrecognized, illegitimated, and misunderstood type of loss or "death")
- Exposure to integrity abuse, (psychological-relational patterns of harm)
- Complex trauma shaping (CTS) of the six systems of psychological functioning

A traumatized, fragmented, and injured ego causes notable functional impairment. When the ego function has been compromised, the result is an unbearable level of anxiety. Such wounding is often associated with primitive defense mechanisms such as splitting, trance states, switching among multiple centers of identity, or psychic numbing (Hartman & Zimberoff, 2012; Jung, 1956). When the ego fragments, one's inner world works to defend the traumatized psyche against further trauma (Hartman & Zimberoff, 2012; Jung, 1956). Although the ego seeks to repair itself by adapting and integrating, the victim's ability to effectively utilize their ego becomes compromised and diminished (Minwalla, 2012). Instead, their ego-reality fragments turn into traumatic memories, painful body experiences, and maladaptive coping patterns. The post-traumatic symptoms themselves can cause alienation and further separate the psyche and the victim from their pre-existing reality-ego. The symptoms can lead to self-blame and self-loathing – additional injuries that must be reconstructed in treatment.

It is important to note that the exposure phase may impact the abuser, the victim(s), the injured relationship(s), child(ren), family systems, and others related to and involved with the family. For example, the abuser may also experience REF, as they no longer have their original, pre-existing sense of self and ego construction (which was based in part on DCSR-related self-denial systems, etc.). Shattering of the abuser's ego can also cause trauma symptoms such as dissociation, fear, grief and loss, negative alterations in mood and thoughts, attachment-based insecurities and reactions, shame, guilt, defensive reactivity, and maladaptive coping mechanisms and personality characteristics.

Keep in Mind

Every person will experience trauma differently and uniquely - not all these injuries or symptoms may apply to everyone

Primary Relational Rupture and Attachment Trauma

This refers to a rupture in the bond between two people, which alone is a traumatic event and causes PTSD symptoms. When the assumptions of attachment are destroyed, the primal sense of safety and protection in the attachment itself is suddenly lost, and this causes significant trauma. An attachment relationship is like a "psychological safety net to catch us if needed."

When faced with life-threatening events, we seek our attachment partner for support as a survival instinct. When the person's protector is the threat, the person is left with not only a traumatic rupture, but also the loss of their support person.

Attachment Injury and Trauma: An attachment injury is characterized by an abandonment or by a betrayal of trust during a critical moment of need. Attachment injuries can act as traumatic events, which then cause post-traumatic stress symptoms and/or insecure attachments and relationship templates.

The intimate partner (abuser) and the relationship (as a third and separate entity can be experienced as having gone a psychological "death" and loss of original cognitive and emotional structures and dimensions of who and what those were)

Describe briefly if and how your partner and the relationship provided you the functions of:

Safety-Net: if you fall or need to fall, they are there to catch you and you rely on your partner and the relationship for this. To what extent is this relationship your safety-net versus other human relationships and attachments that also provide these functions

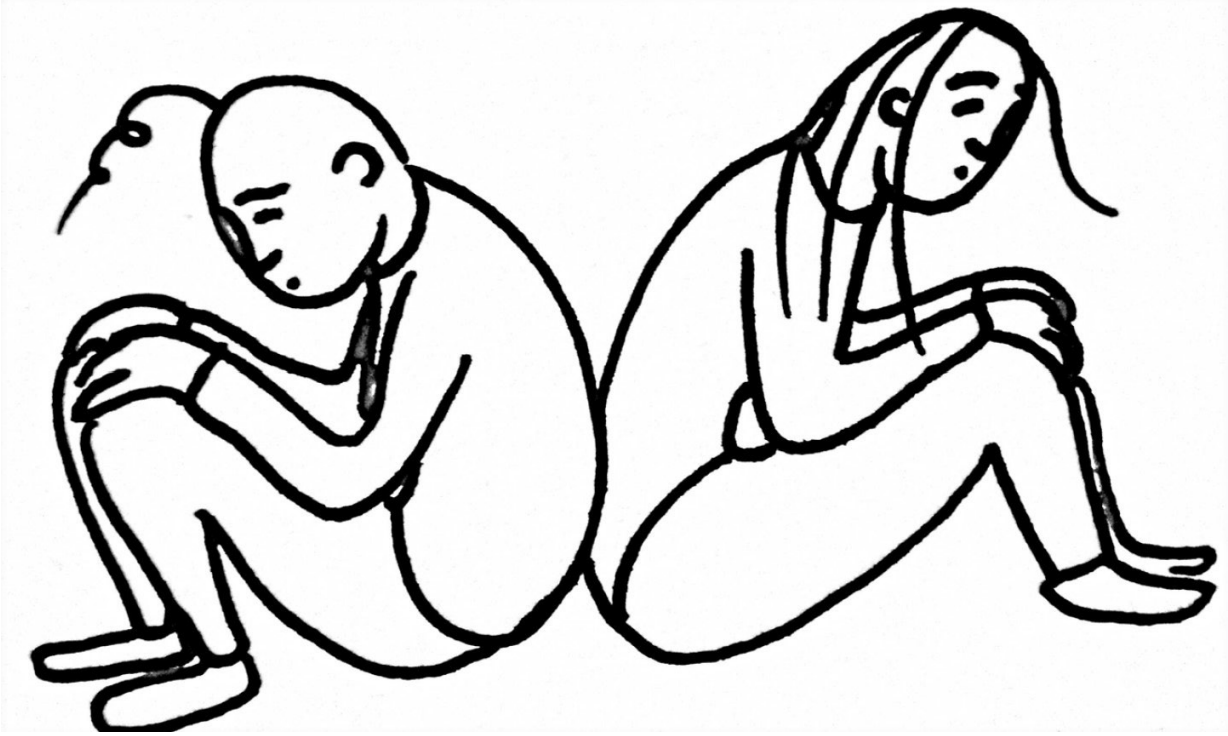
Go-to Person: this is the person and relationship you would turn to and have consciously invested in as your "go-to" person in life-or-death circumstances or when you need someone to tune to or grab onto, they are there

Acute Relational Rupture and Attachment Injury

1. An attachment relationship is a specific type of relationship, where the other person is designated as a "go-to" person and part of the person's "psychological safety net" to catch us if needed (Johnson, 1996).
2. When faced with life-threatening events, or crisis, we typically seek our attachment partner for support as a survival instinct.
3. It is the assumption that you have a safety net and a go-to person that provides stability to the psyche. It is an assumption.
4. Attachment relationships involve a progressive investment in this assumption.
5. We are talking about the loss of an assumption.
6. This shattering of this basic assumption is what causes trauma, loss, and pain.
7. When attachments are destroyed, the primal sense of safety and protection that had come from the attachments are lost (Johnson, 1996). The psyche is no longer operating with this assumption, as it did before the loss.
8. During the exposure phase, the rupture from what may have been previously experienced as a secure attachment, which included some level of psychological and emotional dependency, represents another critical traumatic injury.
9. Because of the exposure to the DCSR, the person that the victim thought they knew and thought they could depend on is no longer there.
10. In fact, that person wasn't there to catch them , but pulled or cut the net.
11. The attachment injury associated with the exposure phase clearly impacts the partner or spouse, but it often also profoundly impacts the abuser too, and then the relationship as a separate, third entity.
12. In other words, the relationship itself – the "us" – is traumatized.
13. This type of relational trauma often causes significant symptoms and defensive coping adaptations in both partners.
14. The significant instability in each person, and between each person, is a source of trauma, as are the numerous failed attempts at re-attachment.
15. All of this causes notable injury to dependency and trust, further detachment, and, eventually, a form of complex trauma that continues to erode the relationship (persistent negative relational patterns).
16. It is also important to note that during this process, the person's previous protector – their "go to person" – has become a threat. In other words, the partner is the perpetrator and the threat from which the victim needs protection.
17. So, rather than the instinctual turn towards that person, there is now a conflicting instinct to guard and protect against this abuser.
18. These opposing instincts cause significant relational dysregulation, confusion, anxiety, and lack of safety anywhere, and the relationship becomes a trigger for each person within it.
19. The victim often becomes terrified of the perpetrator. In addition, the abuser, who possibly also lost their PRE, their sense of attachment, and their psychological safety net, may also become fearful and triggered by the victim and the relational trauma.
20. This can create a back-and-forth pattern of traumatic experience and seeking help from one's partner, followed by attempts to escape and separate from the perpetrator.

Key Points:

1. Safety Net is Lost and the person Hits the Ground
2. Go-To person is the person to lean on for help, support, and protection in times of crisis of life-or-death scenarios – in time of need
3. Go to person is lost and morphs into a threat, no longer someone to turn towards or lean on but instead to defend against
4. The Go-To person cut the Net
5. Remember, the victim's pre-existing reality-ego (PRE)causes PTSD-related symptoms, but so does the attachment injury. So there are 2 separate (but related) sources of PTSD occurring at the same time. That is a lot.
6. Integrity-abuse in the exposure phase makes the abuse and trauma, and attachment injury and prognosis, much worse and more complex and serious in acuity and injurious nature of reality.



A psychological death experience of partner and relationship that impacts safety-net and go-to person as you walk the tightrope of life.

How have your partner's safety net and go-to person functions been impacted?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

1. CA Exercise and Working Out: Exercising the Muscle of Communicating Authentically (CA)
2. Narrate in Writing Exercise: Write or journal the story of what happened here, what you did, for your own reflection and study.
3. Right Brain Exercise: Drawn this room as it exists in AVT-ER; this Specific Behavior; or Dynamic (no words and letters); honest right brain expression for self-metabolization (ISH)
4. Letter from Survivor to You as the Abuser Exercise: Journal or write out a narrative of your victim-survivor(s) expressing how this specific integrity-abuse behavior or dynamic would be expressed, as if you were in their shoes, writing a letter to you, in their voice, the best you can write it.
5. Gestalt Exercise: Step back now, reflect, and "Take in the "Whole" (Right Brain), Sit with; then take notes after sitting with, and meaning make, can sometimes sum up in a word or idea or concept, a condensation and distilled product of the psychological work and exercise.

WTF

Important: Always notice your thoughts, certainly must become aware of your emotions, and then particularly your responses and defenses, **and circle or identify those**, because those are your golden nuggets from your hard work, made more conscious for your continued metabolization, integration and growth.

What's Your Plan Man?

Important: Any Actions to Integrate to Your Work Plan and Practice?

Your Human/Masculine Safety-Net: If you can share and consult and receive IAR feedback and human input from and with your **Conscious Dignifying Circle**, (CDC), even better.

The Breath:

Organic powerful tool of human regulation; regulates all systems of the psychological spinal cord, all six vertebra and every moment. It is always there and available for you to grab onto and use. And it's free. Your organic life-preserver to learn how to use to stabilize, steady, slow down, stay still, sit with, and eventually be vibin.

Inhale IAR = Intentionally Accurate-Authentic Reality (Data, Information, Vibes)

Inhale IAR consciously to help you swim, surf, eat elephant, to metabolize and move through AVT-ER

Nobody is perfect…But every man can become a better man.

And never forgetting but learning to exist and live in a state and condition of remembrance, for the harm we have caused humanity, collectively, and hence we will always lead with a vibe of humility forevermore.

Room 9

Room 9: Hypervigilance, Intrusions, and Persistent Re-experiencing

Intrusions and Re-experiencing (Triggers): This refers to PTSD symptom of re-experiencing the trauma through nightmares, flashbacks, intrusive memories, and cues that remind the person of the injuries and experiences.

Hypervigilance, Intrusions, and Persistent Re-experiencing

In this room, we see:

- Fear, survival, and protection instincts are activated and mobilized
- Needs for safety, security, and self-protection are high priority on the psyche and brain's agenda
- Intrusions may be physical, cognitive, emotional, relational, sexual, social, gender, and/or existential
- Part of what propels persistent and effortful avoidance of distressing trauma-related stimuli are trauma-related thoughts, feelings, and reminders, or internal reminders (re-experiencing)

In order to survive, victims of deceptive sexuality focus on scanning the environment for threats, mobilizing their resources, and being ready to defend and protect the self, reality, children, family, and often the domestic and surrounding sphere. The Diagnostic and Statistical Manual of Mental Disorders (Version 5) notes that PTSD is often characterized by heightened sensitivity to potential threats, including those that are related to the traumatic experience (American Psychiatric Association, 2013).

- **Re-experiencing** refers to situations in which the traumatic experience is "relived" and similar feelings and psychological states are experienced again by the person. The DSM-V describes the symptom of re-experiencing as including spontaneous memories of the traumatic event, recurrent dreams related to it, and/or flashbacks or other intense or prolonged psychological distress (American Psychiatric Association, 2013).
- **Triggers** are reminders or cues that activate memories that cause subjective "reliving" of the traumatic experience for the person.
- The DSM-V also describes the symptom of **arousal** as being marked by aggressive, reckless, or self-destructive behavior, sleep disturbances, hypervigilance, or related problems.

Global Injuries result in the Potential for Global Triggers and Re-experiencing

For intimate partners exposed to deceptive sexuality, triggers are often varied and seemingly endless due to the global and pervasive nature of the injuries. Triggers and re-experiencing of injuries related to the DCSR, reality-ego fragmentation, relational and attachment injuries, second brain activation, and confusion are quite common. Triggers and re-experiencing may also relate to the patterns of integrity abuse that they have suffered, such as lying, deceptive tactics, diminishment, dehumanization, and aggressive verbal abuse. In addition, the person who has created the DCSR and engaged in the integrity abuse can be a potential trigger for the victim, often causing significant relational disturbances. And when reality has been injured as it is in deceptive sexuality circumstances, then the new reality itself (which now includes the DCSR) can be a potential trigger. Many intimate partners report severe, disturbing, and intensely distressing symptoms of posttraumatic triggers and re-experiencing that often contribute to negative relational patterns, which then create additional pain and stress.

Room 9 Symptoms

1. **Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)**. People who have experienced REF often present with recurrent, involuntary, and intrusive distressing memories of the traumatic event (i.e., the collision between the PRE and the DCSR). Recurring, involuntary, and intrusive memories or flashbacks will also bring up distressing emotions and bodily sensations that were part of the traumatic experience.
2. **Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).** The unconscious or the psyche will often express itself in our dreams, and dreams/nightmares may occur in any phase of DST. During the exposure phase more specifically, stressful or disturbing dreams often contain content and/or affect that is related to the DCSR and the integrity abuse. Some victims report explicit dreams in which their partners are cheating or violating them in some way. Others discuss symbolic dreams that represent the DCSR and express the victim's distress.
3. **Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings).** Some victims experience flashbacks during the exposure phase, particularly in the acute and initial stages when there is significant and sudden reality-ego destruction and damage. In fact, it is not uncommon for people to describe this as feeling like the "brain is hijacked" temporarily and that they are re-living and re-experiencing the original traumatic injury or intrusion. They sometimes even lose total awareness of their present surroundings.

4. **Intense or prolonged psychological distress at exposure** to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). This is a common clinical symptom that arises in response to DST and can lead to chronic or episodic anxiety and depression as well as social and recreational isolation. Psychological distress reactions most often occur after prolonged or intense exposure to situations that are triggering (i.e., that remind the victims of their trauma and re-activate the traumatic response system, causing the subjective re-experiencing of the original trauma).
5. **Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).** People experiencing REF will often report highly reactive physiological sensations when they are triggered and re-experiencing trauma. Increased physiological arousal can result in panic-attacks, hypervigilance, startle responses, rapid heart rate, nausea, lack of sleep, uncontrollable shaking, etc.

Important Clinical Note
The post-trauma symptoms experienced in this room can be highly distressing. So many aspects of the victim's experiences are potential triggers. It is important help empower people to be able to cope, manage, and deal with this post-traumatic reality. Primary goals in deceptive sexuality trauma treatment (which follows an empowerment model) include helping the victim find ways to effectively cope with intrusions and learn to regulate and manage the "tidal waves of DST abuse and trauma."

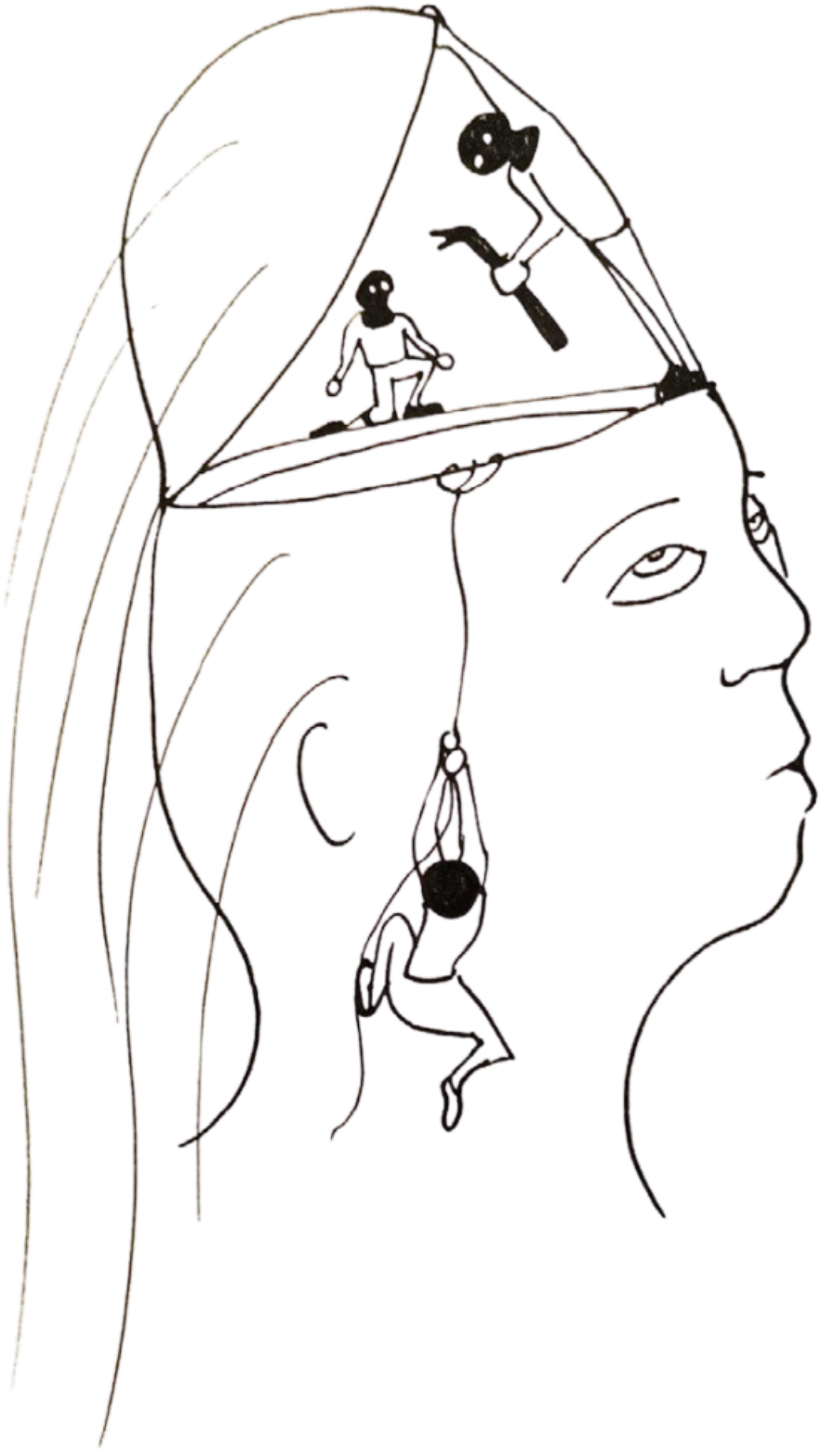
Although the first line of defense against abuse and trauma as human beings often includes denial, avoidance, minimization, and wanting to look away ("This is not really happening…it really is not that bad…I do not want to admit this is real…"), the strategy of only avoiding triggers is insufficient. While of course there may be ways to reduce exposure to triggers via avoidance planning, it is just as important to help the person also build, over time, increased tolerance, resilience, and the ability to effectively deal with triggers and frightening re-experiencing.

Self-study should focus on helping victims – after the tsunami has hit – find stable ground and begin to breathe again (essentially acting as an immediate attachment relationship, a temporary go-to person, and an evolving safety net). As part of this initial stabilization, treatment should slowly assist victims in learning how to swim and surf the waves of abuse and trauma.

Intrusions and Re-Experiencing (Triggers):
This refers to PTSD symptom of re-experiencing the trauma through nightmares, flashbacks, intrusive memories, and cues that remind the person of the injuries and experiences. Triggers are reminders or cues that then activate memories, which cause subjective "reliving" of the traumatic experience. This often triggers a re-experiencing of injuries related to the DCSR, reality-ego fragmentation, relational and attachment injury, second brain activation, and patterns of abuse as well.

Presence of one (or more) of the following **intrusion symptoms** associated with the traumatic event(s), beginning after the traumatic events occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and emotions of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic events were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
4. Intense or prolonged psychological distress with exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).



How has your partner experienced triggers?

What has been your partner's story related to triggers and the secret sexual basement?

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Room 10

Room 10: Avoidance of Trauma-related Stimuli

Avoidance of Trauma-related Stimuli is when the person experiencing this type of traumatic experience may often attempt ways to manage and cope by avoiding and numbing the experience, if possible.

Avoidance of Trauma-related Stimuli

Individuals experiencing this type of trauma often attempt to cope by avoiding and numbing their traumatic symptoms. Avoidance and numbing are strategies for coping with the psychological pain, confusion, horror, and disorientation as well as the intensely experienced distressing and overwhelming emotional, psychological, and relational disturbances and alterations that are associated with deceptive sexuality.

Some victims may try to avoid **distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).** During the exposure phase, victims may intentionally avoid distressing memories, thoughts, or feelings related to the DCSR and the integrity-abuse. Some may try to steer clear from graphic sexual images and narratives or emotionally intimate forms of exchange related to the DCSR. Others may try to avoid the arguments, defensive reactions, and other integrity-abuse behaviors that may occur during the exposure phase. For example, a victim may not be able to watch a specific movie due to content that resembles the DCSR, the integrity-abuse behaviors, or any of the injuries experienced during the exposure phase. They may not be able to go to a beach or sit in a public pool because of intense exposure to something that symbolizes an aspect of the secret sexual basement. Another form of avoiding is to numb, medicate, or find methods for blotting out pain, circumventing the intensity or severity of symptoms and decreasing the potential for re-experiencing. Individuals may numb themselves by "checking out" using technology and social media, drinking alcohol, and/or taking drugs. They may experience detachment or derealization, depersonalization, and challenges being present.

Clinical Memo:
It is easy for people to use technology as a form of posttraumatic coping to avoid pain, but this can lead to dependencies.

Others attempt to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). Some victims are overwhelmed and triggered by their deceptive partners that they need to live separately simply to avoid the type of prolonged psychological distress that being around them causes. Others avoid friends and family members that they used to see while with their partners because being around them causes great distress. This type of constriction in an effort to avoid the distress that comes from re-experiencing such difficult trauma is common among victims both during and after the exposure phase. As a result, such victims' worlds get smaller, and they may, unfortunately, experience a reduced social support network as a result.

Clinical Conceptualization: Like a Potato Bug
Another term for this symptom is constriction. Constriction can be metaphorically conceptualized as the reaction of a potato bug when threatened – the bug curls up and pulls inward towards itself as a form or survival and protection. Humans do this too. Their world gets smaller as they constrict and attempt to protect themselves and cope with a threatening external environment.

The survivor may avoid or numb by:

- constricting their body (e.g., going into the fetal position, hands become fists, jaws clench)
- constricting their thoughts (e.g., "Just don't go there" and "Don't think about it")
- constricting their emotions by "clamping down" on emotions – not feeling emotions or detaching from emotions altogether; emotions may be placed in the body (somatic responses as coping)
- withdrawing from recreational activities – they may stop doing things they once enjoyed
- withdrawing from socializing, spending time with friends, and being in public – they may start staying at home, in their room, or even in bed (e.g., developing symptoms of agoraphobia)

These are all forms of post-abuse and traumatic implosion and constriction.

Avoidance of Trauma-Related Stimulus

The person experiencing this type of traumatic experience may often attempt ways to manage and cope by avoiding and numbing the experience, if possible. Avoidance may often be an attempt to avoid re-experiencing being triggered by an external or internal cue that comes from experiencing exposure to life and activities of reality or daily living. Avoiding places, people, and situations that are obvious triggers are common among partners and spouses impacted by this type of trauma. One way of avoiding is to numb, medicate, or find methods for blotting out pain and avoiding the intensity or severity of the symptoms or the potential for re-experiencing.

Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidence by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, of feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activates, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Questions:

- **a.** It is easy for people to use technology as a form of post-traumatic coping to avoid pain. Does this apply to you and describe extent and nature?
- **b.** How dependent are you on your escapes and coping mechanisms?
- **c.** Are any concerning to you?

Educational Metaphor: Constricting "like a Potato Bug"

How has your partner's world gotten smaller as a result of avoidance of trauma-related stimuli?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

1. CA Exercise and Working Out: Exercising the Muscle of Communicating Authentically (CA)
2. Narrate in Writing Exercise: Write or journal the story of what happened here, what you did, for your own reflection and study.
3. Right Brain Exercise: Drawn this room as it exists in AVT-ER; this Specific Behavior; or Dynamic (no words and letters); honest right brain expression for self-metabolization (ISH)
4. Letter from Survivor to You as the Abuser Exercise: Journal or write out a narrative of your victim-survivor(s) expressing how this specific integrity-abuse behavior or dynamic would be expressed, as if you were in their shoes, writing a letter to you, in their voice, the best you can write it.
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WTF

Important: Always notice your thoughts, certainly must become aware of your emotions, and then particularly your responses and defenses, **and circle or identify those**, because those are your golden nuggets from your hard work, made more conscious for your continued metabolization, integration and growth.

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Room 11

Room 11: Negative Alterations in Thought and Mood

The thought system is often dominantly in a state of fear; thoughts related to an agenda of survival and protecting from threats and harm will dominate the thought system.

Negative Alterations in Thought and Mood

Important Diagnostic and Symptom Information:
According to the DSM-V (2013), negative alterations in cognitions or mood associated with the traumatic event begin or worsen after exposure to the event. These negative alterations can take various forms and are what people may experience post-trauma in the DST exposure phase, after reality-ego fragmentation, attachment injury, and ongoing integrity abuse.

Alterations to Cognition
The DSM-V (p. 275) notes that post-traumatic negative alterations to cognition (thought system) may include:

- Dissociative amnesia or hypermnesia (Herman, 1997)
- Persistent and exaggerated negative expectations regarding important aspects of life applied to oneself, others, or the future
- A negative change in perceived identity since the trauma
- Persistent erroneous cognitions about the causes of the traumatic event that lead them to blame themselves or others

DST-related alterations to cognition (thought system) may include:

- **Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").** Many victims of DST will experience persistent and exaggerated negative beliefs or expectations about themselves, others, and/or their worlds. In fact, negative ruminative preoccupations such as fear-based beliefs and shame-based thoughts are quite common as individuals and their psyches attempt to cognitively metabolize their injuries, most notably their fragmented PREs. Victims may live in fear of continued deception, or they may worry about specific sexual behaviors that they discovered in the DCSR. They may have fears related to the impacts of the DCSR on their children and family systems. They may question themselves ("How could I have not known?") and think negatively about themselves for not knowing ("I feel like an idiot"). Victims might also begin to experience rage-based schemas, thoughts, and beliefs that lead to feelings of anger, revenge, and violent and aggressive responses. Finally, the exposure phase also likely brings with it notable alterations in how victims think about their existence, humanity, faith, and spirituality. It is not uncommon to see the foundational components of spiritual conceptualization and meaning of life be significantly altered during the exposure phase.

- **Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.** During the traumatic events and injuries that victims experience in the exposure phase, victims' psyches and thought systems are tasked with processing a huge amount of painful content and information. Because of this, victims often do not have rational, well-developed thoughts about the causes and consequences of the DCSR. In fact, victims often tend to preoccupy themselves with persistent, distorted thoughts about the causes or consequences that are perceived through subjective traumatic filters or lenses. Specific traumatic images or content can become anchor points or have significant personal meaning for victims, which leads them to amplify those potential causes and consequences and disregard or refute other potential realities. Many victims will end up blaming themselves and trying to figure out exactly how they contributed to the problems. This self-blame is sometimes compounded by society and even within therapeutic environments, where some victims feel unjustly blamed for the DCSR.

- **Some victims develop a preoccupation with the abuser – they become focused on attending to threats and ensuring their survival.** Being in an abusive relationship may, over time, develop into a dynamic where the victim's psyche becomes preoccupied with the abuser. There can sometimes be various types of thinking strategies used to cope, as well as symptoms such as learned compliance, compartmentalization of the abuse, morbid preoccupation, revenge obsessions, and an attribution of power that becomes projected onto the abuser. This happens as the victim's psyche becomes weaker and their self-perceptions deteriorate, making them feel powerless and ineffective against the abuser and the abusive system. The victim's own internal, self-related power may be projected and externalized.

Alterations to Mood

The DSM-V (p. 275) notes that post-traumatic negative alterations to mood (emotional system) may include:

- A persistent negative mood state (e.g., fear, horror, anger, guilt, shame) that either began or worsened after exposure to the event
- A persistent inability to feel positive emotions (especially happiness, joy, satisfaction, or emotions associated with intimacy, tenderness, and sexuality
- Markedly diminished interest or participation in previously enjoyed activities

DST-related alterations to mood (emotional system) may include:

- **Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).** Another common symptom during the exposure phase, as the person attempts to process the initial shock, horror, and loss resulting from discovery or disclosure of the DCSR, are persistent negative emotional states. Ongoing feelings of fear, anger, depression, grief, blame, and shame are all common during this time. Forms of clinical anxiety and depression may also emerge during the exposure phase. Victims are also likely to feel that they are on an "emotional roller coaster" due to the waves or cycles of trauma that they experience and the difficulty regulating their emotions throughout such unpredictable, trying times. Betrayal trauma may be associated with alexithymia, depression, and anxiety (Freyd et al., 2005). The persistent negative emotions that victims feel during the exposure phase likely also contribute to problems in relational functioning or social functioning, which, in turn, may exacerbate negative emotions, thereby creating a vicious cycle.

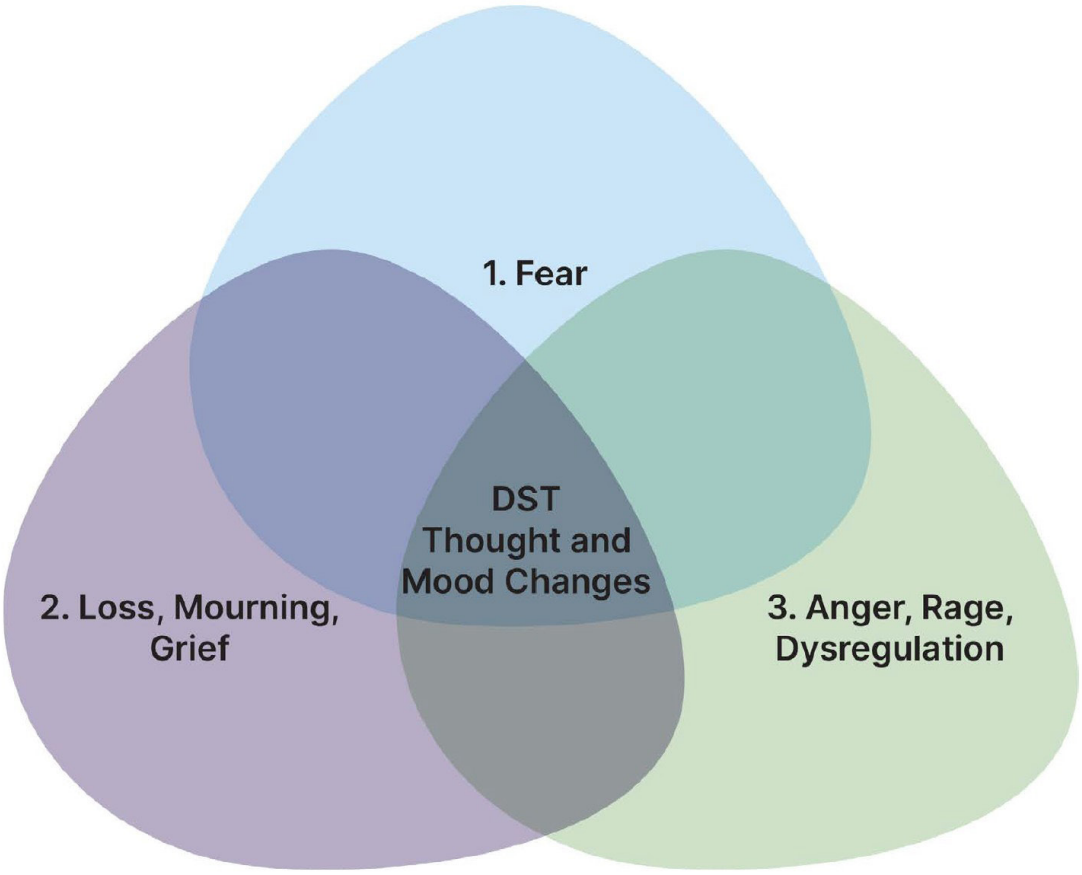
- **Markedly diminished interest or participation in significant activities.** When a person experiences REF, which may feel like a tsunami or the crumbling of their house's foundation, they often have very strong survival/protective responses such as constriction (e.g., clenched fists and jaws) which can generalize to thoughts and emotions. If this happens, people might stop doing things that they enjoyed doing before the exposure phase. They may be less likely to engage in work, hobbies, socializing, talking, or touching in an attempt to protect themselves and stay safe. For example, a marathon runner may immediately stop running, or a graduate student may drop out of school. Sadly, the energy required to be interested and to engage in such activities is just too much for these victims to handle. Decreased interest or participation in these types of activities may also result from hypervigilance and an avoidance of stimuli that may force a re-experiencing of the trauma and/or a paralysis of initiative that results from damage to the ego during the exposure phase.

- **Feelings of detachment or estrangement from others** The discovery of the DCSR and its content during the exposure phase can cause feelings of estrangement or detachment from others. The survival and protection instincts that are associated with the exposure phase may result in avoidance of human interaction, which, in turn, can lead to social isolation. Forms of traumatic dissociation or numbing may also cause feelings of detachment and estrangement. Sometimes victims will end up feeling pervasively misunderstood by others and, as result, feel strongly alienated from them. While many people perceive cheating as wrong, most (including treatment providers) do not hold the perception that DCSRs and integrity-abuse behaviors are forms of emotional, psychological, and relational abuse. Because of this, many victims do not feel that their experiences are adequately recognized, validated, or legitimized, and they end up feeling detached or estranged from others. Many victims also feel traumatically disoriented, as their previous go-to person and safety net have become threatening, abusive, and no longer a source of support. In addition, because of ongoing significant and severe complex trauma, some victims feel like they are outside the systems of protection that others possess and, thus, feel somewhat ostracized from the rest of society.

- **Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).** The overwhelming pain and confusion associated with REF can lead to an ongoing inability to experience positive emotions. This often leads to the further avoidance of activities and the isolation that creates a downward spiral that increases emotional despair.

DST-related Negative Alterations to Thought and Mood
People going through the exposure phase and experiencing post-trauma from deceptive sexuality may be likely to encounter the following core cognitive-emotional dynamics:

- **Fear.** During the exposure phase, the victim's thought system is often dominated by a state of fear. Fragmentation of reality and self-perceptions, along with critical attachment injuries, immediately shift the brain to fear or survival mode. Victims' thoughts usually focus on survival and protection from threats and harm, which then impact emotions and mood. Indeed, PTSD and trauma can be conceptualized as conditions of fear in which the brain and the psyche are in survival mode due to perceived threat. When the psyche switches to a fear-based survival mode, the organizing or dominant agenda involves scanning the environment for threats and being prepared to respond, defend, and protect. Notably, fear is the root emotion of anxiety; thus, anxiety disorders are common both during and after the collision of the PRE with the DCSR.
- **Loss, Mourning, Grief.** In addition, the sudden loss of self and PRE, as well as the attachment in its previous condition, can all be severe and experienced as extremely distressing and intense. When all previous perceptions of reality are suddenly called into question and negatively altered, these types of losses result in significant grief. As discussed above, the REF is often experienced as a "psychological death" and associated with a grieving process.
- **Anger and dysregulation.** When someone comes to realize the deceptions, as well as the degree and nature of the violations, that existed during the covert phase, they often feel a deep sense of betrayal. As a result, they might experience significant emotional and behavioral dysregulation. They might also react intensely with anger and rage. People describe such emotions as "coming in waves" or "like being on an emotional roller coaster" and will often require help with managing and coping with such intense and potentially debilitating alterations in thought and mood patterns.



Examples of DST-related Alterations to Thought and Mood

- Thought system is focused on and attentive to survival from threats
- Inability to recall key features of the traumatic event
- Persistent negative beliefs and expectations about oneself, relationship, family, or reality
- Persistent blame of self or others for causing the traumatic event or for resulting consequences
- DCSR intrusion processing (thought system and mood
- impacted as the victim metabolizes the reality of injury and trauma)
- Depressive, rage, and/or fear-based cognitions
- Parental instincts (e.g., "Mama bear")
- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame)
- Increased anxiety or panic attacks
- Depressive symptoms, crying, sadness, grief
- Markedly diminished interest in (pre-traumatic) significant activities
- Feeling alienated from others (e.g., detachment or estrangement)
- Constricted affect – persistent inability to experience positive emotions
- Persistent dysphoria
- Chronic suicidal preoccupation
- Explosive or extremely uninhibited anger
- Compulsive or extremely uninhibited sexuality

Research and Education

Research and Education Corner
It is important to account for the integrity abuse here. According to Gómez and Freyd (2019): "The presence of DARVO in victims' accounts of confronting their perpetrators is clear: Through denying, minimizing, attacking the victim, and claiming to be merely misunderstood (possibly with the hope of being cast in a victimized light), perpetrators compel their victims to doubt their own evaluations of the abuse and promote confusion surrounding its occurrence" (Gómez & Freyd, 2019, abstract).

This means that the continued integrity abuse, which may include continued gaslighting and manipulation or deception, is going to impact the victim's thought system and emotional system here in this room, in additional to the aftermath of trauma.

Due to reality-ego fragmentation, attachment injury, and the post-traumatic stress that results, we expect to see negative alterations in thought and mood. But the integrity abuse here, when the person is in acute distress and trauma, confuses and harms the person's thought system and emotional system even more.

Betrayal Trauma Symptoms
According to Freyd (1996): Betrayal traumas are different from PTSD and independent of post-traumatic stress reactions. Betrayal trauma, or trauma perpetrated by someone with whom a victim is close, is strongly associated with a range of negative psychological and physical health outcomes, including physical illness, alexithymia, depression, and anxiety (Freyd et al., 2005). DST includes, but is distinct from, betrayal trauma (which is distinct from PTSD) – they overlap but are different and distinct as well.

According to Gobin and Freyd (2014), early experiences of violation perpetrated by close others, or betrayal traumas, may interfere with developing social capacities, including the ability to make healthy decisions about whom to trust. In Gobin and Freyd's (2014) study, high betrayal trauma exposure was associated with lower levels of self-reported general and relational trust.

According to Freyd (1991), the "trauma of child abuse by the very nature of it requires that information about the abuse be blocked from mental mechanisms that control attachment and attachment behavior" (p. 81). This statement describes how our thoughts can be utilized to protect us by forgetting, distorting, minimizing, and otherwise doing whatever mental gymnastics may be necessary to survive and cope. With DST, victims may rely on cognitive alterations to deal with their connections with the abuser and associated feelings of disempowerment, dependency, and entrapment – realities that would have to be confronted to escape.

Negative Alterations in Thought and Mood

DST-related Negative Alterations to Thought
The traumatized person may experience negative alterations in both thought and mood. The thought system is often dominantly in a state of fear; thoughts related to an agenda of survival and protecting from threats and harm will dominate the thought system. Instead of healthier states of mind, such as being open to new human experiences in the service of healthy evolution as a human being – which may have existed prior to the injury – the person's thoughts are preoccupied with a system of protection and survival. Negative alterations in cognition associated with the traumatic event(s), beginning, or worsening after the traumatic event(s) occurred, as evidenced by one (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to the other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am stupid," "No one can be trusted," "The world is completely dangerous," "He is a monster")
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead individuals to blame self or others.
4. Reliving traumatic experience through ruminative preoccupation

Negative alterations in mood associated with the traumatic event(s), beginning, or worsening after the traumatic event(s) occurred, as evidenced by one (or more) of the following:

1. Persistent negative emotional state (e.g., fear, horror, anger, shame, grief).
2. Markedly diminished interest or participation in significant activities.
3. Feelings of detachment or estrangement from others.
4. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

How did your partner's thoughts and mood change post-discovery and post exposure?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

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Room 12

Room 12: Trauma-related Arousal and Reactivity

Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning, or worsening after the traumatic event(s) occurred.

Trauma-related Arousal and Reactivity

Post-traumatic Trauma-related Arousal and Reactivity
The DSM-V (pp. 275-276) notes the following about posttraumatic trauma-related arousal and reactivity:

- Individuals with PTSD may be quick tempered and may even engage in aggressive verbal and or physical behavior with little or no provocation (e.g., yelling at people, getting into fights, destroying objects) – Criterion E1
- Individuals with PTSD may engage in reckless or self-destructive behavior such as dangerous driving, excessive alcohol or drug use, or self-injurious or suicidal behavior – Criterion E2
- PTSD is often characterized by a heightened sensitivity to potential threats, including those that are related to the traumatic experience – Criterion E3
- People with PTSD may be very reactive to unexpected stimuli, displaying a heightened startle response or jumpiness – Criterion E4
- Problems with sleep onset and maintenance are common
- Generalized elevated arousal may also be common

These experiences are similar to what people may go through in the DST exposure phase – after reality-ego fragmentation, attachment injury, and ongoing integrity-abuse. During the exposure phase, victims' brains are often in fear mode, and their systems are "on guard" (some victims have described their state of mind as "waiting for the next shoe or bomb to drop"). The specific fear responses and re-experiencing triggers that so many victims suffer through during the exposure phase all contribute to the risk of post-traumatic stress symptoms (including intense fear, panic, and horror). The brain literally
goes into survival mode, where primary/regressed defenses
dominate the psychological system, causing a hypervigilant
state of survival, scanning for threats, and preparing to respond. Specific types of emotional, psychological, and relational harm and abuse (e.g., victim-based aggression or episodic physical violence against others) may also occur during this phase.

More specifically, DST post-traumatic trauma-related arousal and reactivity may include:

- **Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.** Reactivity associated with the fear, hypervigilance, and protective defense mechanisms that are associated with this phase may present as irritable behaviors, angry outbursts, and verbal or physical aggression toward abusers, other family members, or random objects in the environment. Indeed, aggression is a common reaction for many victims, particularly upon discovery and disclosure of the DCSR and in response to integrity-abuse

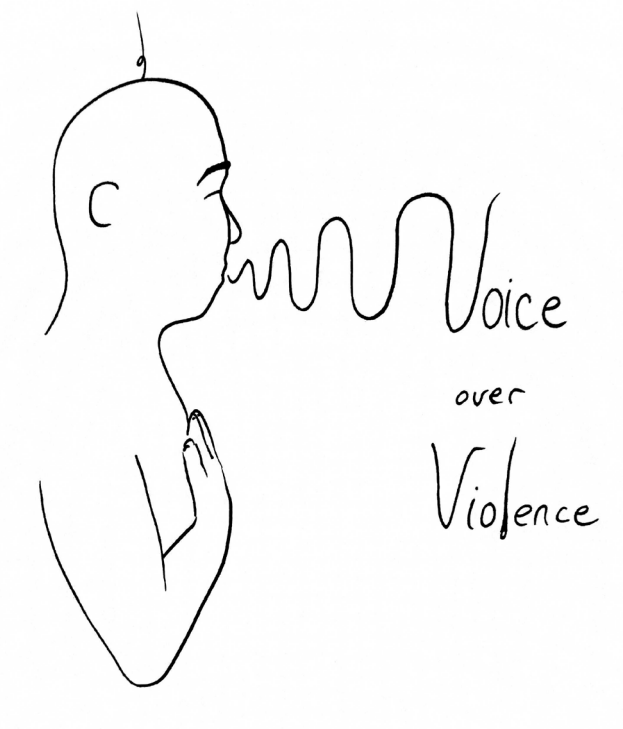
- **Reckless or self-destructive behavior.** Reckless or self-destructive behaviors can occur during the exposure phase as an attempt to cope with the pain, disappointment, and disorientation associated with this time. Reckless or self-destructive behaviors may include the use of drugs or alcohol, revenge behaviors (e.g., stalking), or manipulation (e.g., lying or impersonating to gain information). For example, victims might attempt to get in contact with the affair partners and ask direct questions or go to a strip club to see what it feels like to be in the DCSR environment. These types of behaviors are attempts to cope with the challenges of this phase, though they often, unfortunately, end up hurting the victims at times.

- **Hypervigilance.** Victims of psychological trauma often find themselves in situations where they are retraumatized and forced to re-experience intense pain (Kalsched, 1996). Specific internal/external and objective/subjective stimuli, perceptions, thoughts, feelings, or sensations will remind the psyche of the trauma, and the system will react to the stimuli, causing emotional changes related to fear, panic, and feelings associated with traumatic memory (Jason, 2009). As a result, these victims are often hypervigilant, on guard, or in fight or flight mode. For example, they may persistently scan for anything that resembles the DCSR or integrity-abuse behaviors to protect themselves against these types of threats. It only makes sense that another unknown piece of the secret sexual basement may emerge at any time when it is one of deception, and it makes sense that abusers would be motivated to not get caught or discovered. So, here it becomes very likely that the victim's brain and psychological systems will naturally be experiencing anticipatory anxiety, waiting for the next "shoe or bomb to drop." This type of thinking makes perfect sense in terms of survival and human beings.

- **Exaggerated startle response.** Deceptive sexuality victims are often inundated with fear and perched on an unstable foundation. When they are triggered, surprised, or otherwise emotionally jarred, they are likely to show exaggerated startle responses to common situations such as being touched on the shoulder or hearing a loud noise. Victims in these instances are physiologically sensitive to potential threats in their environments and react involuntarily through an exaggerated startle response.

- **Problems with concentration.** During the exposure phase, victims often experience concentration problems due to depression or anxiety, intrusive thoughts and images, flashbacks, and/or nightmares (and the lack of quality sleep that often comes along with them). Victims are also often distracted by being triggered and re-experiencing their DCSRs as well as having to live through the various integrity-abuse behaviors carried out by their partners. Problems with concentration during the exposure phase often impact daily functioning, parenting, self-care, etc.

- **Sleep disturbance** (e.g., difficulty falling or staying asleep or restless sleep). Many deceptive sexuality victims also report sleep disturbances such as insomnia due to hyper-arousal, fear and anxiety, rage, and ruminative preoccupation. Others tend to sleep more than usual and/or have difficulty waking up. It is also not uncommon for victims to try to process the trauma and the injury with their partners at night, which often leads to interruptions to normal sleep patterns.

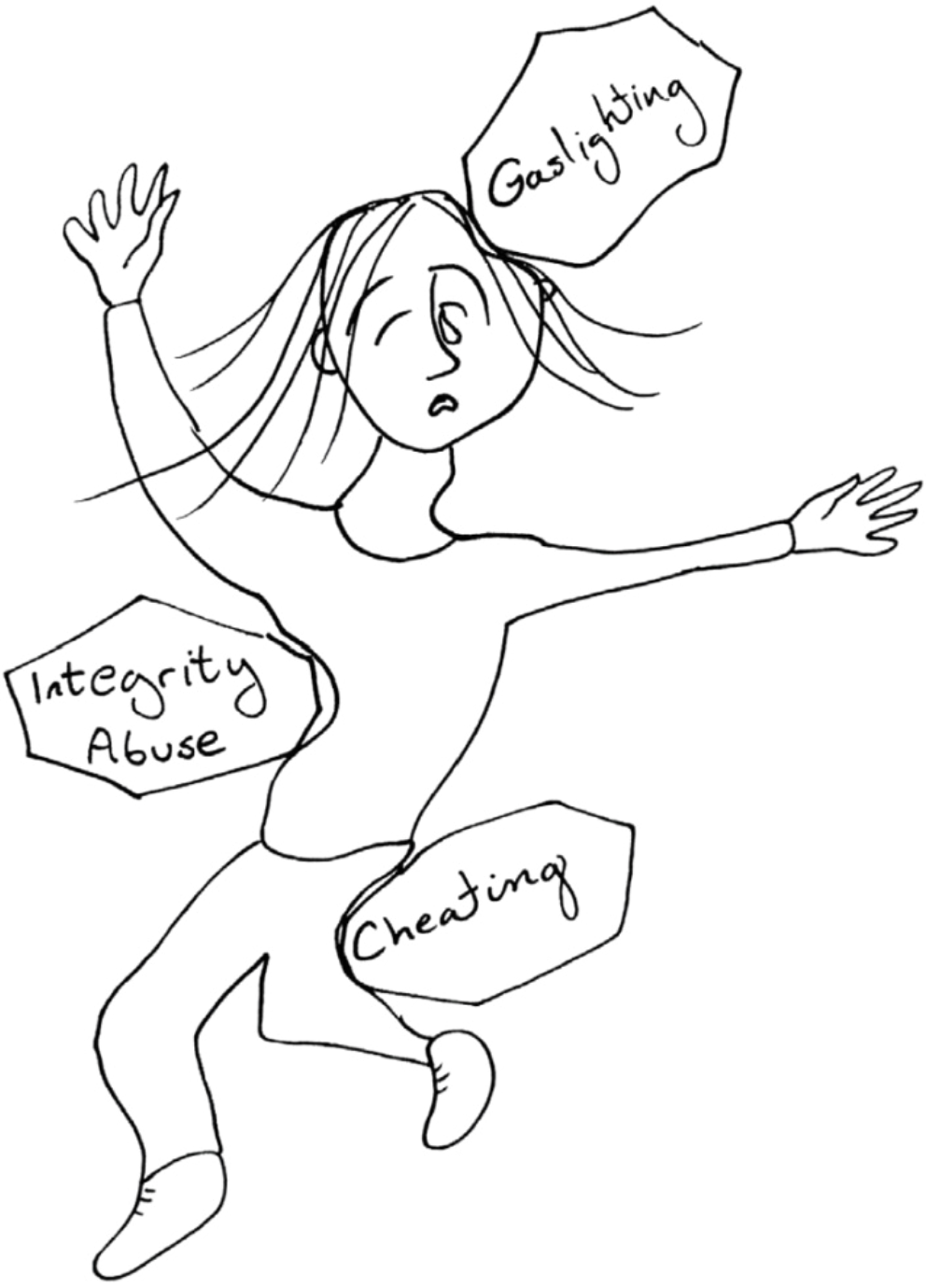


Trauma-related Arousal and Reactivity
Specific fear responses and re-experiencing contribute to the development of post-traumatic stress symptoms. The brain is in fear-mode, and thus the mind and the system are "on guard," sometimes described as "waiting for the next shoe or bomb to drop." Because this type of trauma results from having experienced ongoing deception, manipulation, and abuse, the post-traumatic symptoms of arousal and reactivity will likely increase anger, rage aggression, and protective instincts that, when pressed, can lead to verbal aggression or violence. This is normal and to be expected and requires skilled clinical management and care.

Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning, or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Clinical Note
Symptom reactions tend to be used to reverse the victim/abuser roles, deflecting attention away from the abuse/abuser and making the victim seem crazy (there may be legitimate behaviors to point to make that case). But the point here is that these reactions are the result of the abuse and injuries, first and foremost. Clinicians should focus on helping the survivor rather than blaming or pathologizing their reactions, while at the same time helping to manage and contain their reactions as part of stabilization – facilitating healthy emotional regulation and helping them learn how to "swim and surf" the waves of abuse and trauma.



Often reactivity is related to fear, grief/loss and anger/rage and defense of self, children, or family.

How did your partner become aroused and reactive post-exposure to DCSR and what is your partner's reactivity story?

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Room 13

Room 13: Distress and Functional Impairment

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Distress and Functional Impairment

Individuals who experience continued integrity abuse, along with REF, relational rupture, and attachment injury – usually all at the same time – often suffer from acute distress and functional impairment that can persist from months to years. These dynamics are a significant source of stress that alone can cause functional impairment. Unfortunately, such destabilization can sometimes cause people to submerge deeper into their trauma symptoms and present even greater obstacles to working through the traumatic experiences. The literature on this topic demonstrates that "physical, sexual, and psychological abuse not only often result in lifelong physical and mental health consequences for those involved, but they also can impact interpersonal, social, and economic functioning" (American Psychological Association, 2010). This is often the case for intimate partners and families impacted by
DST.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. As described in detail above, the exposure phase is a collision that destroys victims' pre-existing realities and alters their entire worlds. This impacts social functioning, occupational functioning, and other important areas of functioning. Victims' external worlds, on a practical level, may become destabilized, and routine functions related to childcare, finances, and friendships may be thrown off. Some people will experience bodily impacts, medical symptoms, and/or sexual and gender wounds. There are also specific experiences in treatment that may exacerbate or add to the trauma suffered during the exposure phase.

More specifically, people experiencing DST may experience the following forms of distress and impairment:

- **External crisis and destabilization.** One form of distress that is important to recognize in assessing and treating deceptive sexuality trauma is external crisis and destabilization, which often occurs during the exposure phase. External crisis and destabilization refers to major disruptions to a person's environment on a practical level (e.g., significant changes in routines, living arrangements, family structures, co-parenting functions, resources, financial burdens, etc.), which often exacerbate or compound previous traumas and cause a person to submerge deeper into their trauma symptoms. For example, there are families that must move from their neighborhood because there was an affair or sexual partner in the neighborhood, maybe someone the victim knew or trusted (i.e., another interpersonal betrayal). A move like this results in the children of each family potentially experiencing attachment injuries and loss. This is where there is chaos and destabilization, not just internally or psychologically or relationally, but the victim's entire day to day life can be reshaped and destabilized in many ways during this exposure phase. This will cause additional distress and functional impairment.

- **Occupational functioning impairment.** Occupational functioning may be negatively impacted during the exposure phase. Depressive symptoms, fear, and anxiety symptoms, and/or concentration problems are likely to interfere with the ability to perform and adequately function in one's job. For example, artists, teachers, therapists, or athletes may simply not be able to perform while they experience post-traumatic symptoms because of REF and integrity-abuse behaviors. Sometimes, victims will have to take a break from their jobs and go on disability. Others may drop out of school and may never complete their career goals. Those who are able to work may experience concentration challenges and/or intrusive thoughts while on the job, which likely decrease the quality of their performance and cause significant distress.

- **Physical functioning impairment.** The trauma experienced during the exposure phase can impact the functioning of a person's physical body. We know that people who have experienced traumatic events have higher rates than the general population of a wide range health concerns, as well as serious and sometimes life-threatening illnesses, including cardiovascular disease, diabetes, gastrointestinal disorders, and cancer (Kendall-Tackett, 2009). Deceptive sexuality trauma has been associated with increased medical symptoms as well as problems with body image, which can trigger eating disturbances and even lead to eating disorders. In addition, some medical conditions are highly sensitive and relate directly to bodily disturbances associated specifically with DST. In addition, during the exposure phase, some victims realize that they are at risk for sexually transmitted infections because their partners engaged in unprotected sexual activities with other people.

- **Sexual functioning impairment**. In cases where abusers force sexual activity with their partners, the partners may dissociate or withdraw psychologically in order to cope and endure. On the other hand, hypersexuality may occur during the exposure phase as a primal fight response. Victims may fight to claim what is "theirs," to prove to themselves that they are still sexually viable and attractive, to temporarily affirm gender esteem, to search for basic connection, and/or to attempt to gain reattachment to the abusive partner. Sadly, hypersexuality is sometimes mistaken as a sign of health, even though it is often a post-traumatic response that is associated with potential harm. Indeed, many partners report regret for what happened to their bodies in the context of post-traumatic hypersexuality during the exposure phase.

- **Gender identity and esteem impairment.** Victims are often profoundly impacted at the core of their gender (Jason & Minwalla, 2008), and their gender identities, gender schemas, and gender esteem may be significantly impaired during the exposure phase. This can include damage to core gender schemas and constructs such as wife, mother, female, sexual being, worthy being, and body image. The impact of gender wounding on overall psychological health and functioning is often unconscious and unrecognized. However, gender identity and esteem are primary dynamics in self-construction and self-worth and are foundational to global psychological functioning and adjustment.

- **Family functioning impairment.** Deceptive sexuality trauma impacts all family members either directly or indirectly. During the exposure phase, the mother-child bond, the family unit as whole, and the home environment often feel like they have been invaded. Integrity-abuse behaviors all significantly impact children and other family members. Oftentimes secrets are held from one or more family members, which leads to a loss of relational integrity among these family members (not just between the abuser and their partner). Children, in particular, will likely experience some level of trauma from the types of disruptions that are experienced because of the collision between the PRE and the DCSR. Mothers, in turn, will likely feel a sense of trauma from watching their children suffer. Mothers watching their children experience trauma symptoms due to the DCSR will often be reminded of and will re-experience the original trauma and will feel a deep sense of rage and other emotional reactions. There are often also unhealthy alliances within family systems during the exposure phase, and some abusers may even blame their children for the DCSR. For example, an abuser whose pornography is discovered on his wife's computer may, upon confrontation, lie and offer the intentional manipulated reality (IMR) that the porn is definitely and absolutely not theirs, but is instead their son's and that "all young teens do it, so don't bother him about it!" In addition, some victims may, while they are trying to recover from their trauma, unintentionally use children as self-soothing objects Children can be used as soothing objects or parentified, and other unhealthy interpersonal dynamics may emerge here.

- **Social functioning impairment.** DST also has implications for other relationships (e.g., friendships), for how one feels being in public, and for perceptions about community and how it can provide stability. The victim may begin to lose integrity in relationships, meaning that they may not share honestly any more or they may avoid sharing with friends with whom they would normally be open with. Other people may have also betrayed the victim, so these people may be lost to the victim, they may withdraw from the victim, or the victim may grow away and apart from them. The ways that other relationships are impacted are unique to each person and can be significant sources of grief and loss, as well as destabilizing when they previously served as safety net functions.

- **Existential crisis.** The experiences that victims often have during the exposure phase, especially REF, may cause existential crises that lead to emotional, psychological, and relational distress. Indeed, existential trauma or spiritual trauma is itself a form of ego fragmentation, representing cracks to a foundational structure on which much of the psyche is organized. The human psyche relies on a vital stabilizing relationship with elements that are beyond the ego or the self (e.g., God, the universe, the unconscious). The vital relationship to "that which is beyond" (transpersonal) and that which supports us and protects us (divine) (Herman, 1997) can be seriously impacted by the structural ego-reality damage and injury that is often experienced during the exposure phase. Foundational components of spiritual conceptualization and meaning may be significantly altered during this time. To the extent that spirituality, religion, faith, and other existential factors provide us with stability and strength, victims may be crushed by the DST and may collapse deep within their souls.

Clinical Note
Although many people dealing with DST do attempt, in varying ways, to keep relating to the abusive partner in the exposure phase, it is often distressing for a victim to do so. It is an intense and potentially volatile situation – and particularly painful and demanding on the victim – to be cohabitating or relating with the abuser immediately post-abuse or while still being harmed by integrity abuse. Sometimes the victim may feel trapped with someone they no longer recognize or feel safe or secure with. Sometimes they may feel too disempowered to even ask to sleep separately in another bed and may feel trapped sleeping next to "an imposter," etc.

Survival Submersion

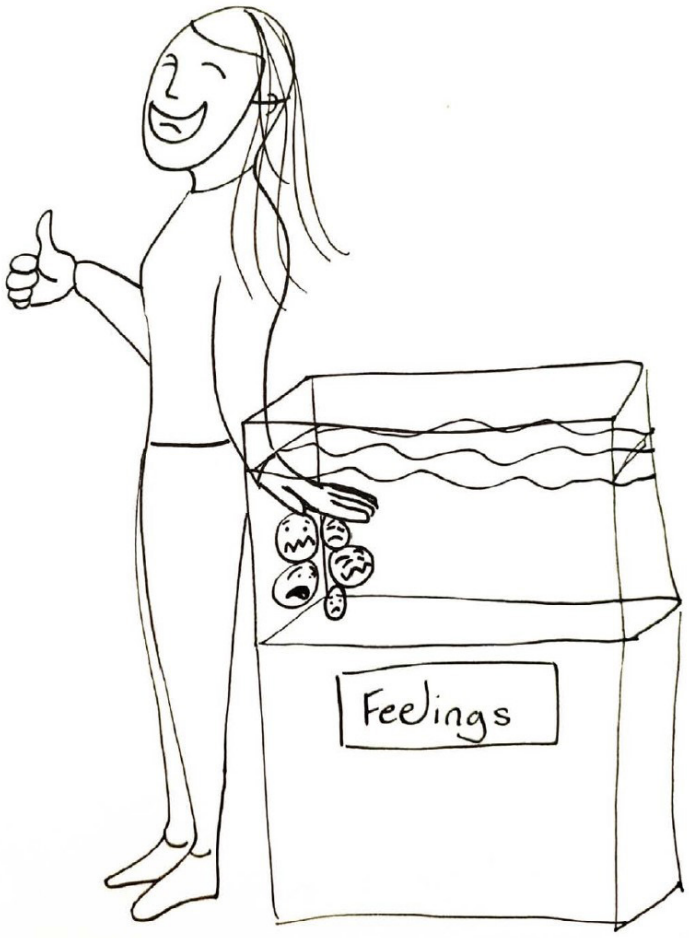
At this point in the exposure phase, we may see what can be referred to as survival submersion of traumatic symptoms. Survival submersion is a type of survival constriction tactic where the victim submerges certain traumatic and abuse symptoms so they can be functional. This strategy is often used by mothers, especially of young children. A deep, primal maternal instinct emerges and submerges the trauma – allowing the mother to go into administrative mode – for the sake of her children's survival and thus her own.

Holding Down the Fort (while on the road, hemorrhaging due to the car crash)

Oftentimes, the abuser will go to treatment in the exposure phase, right after the REF, attachment rupture, and ongoing integrity abuse (2 to 4 weeks after the discovery/disclosure, as an example). The abuser may also move out of the family home at least temporarily. It is important to understand that when society and even treatment sees the person who had engaged in the deceptive sexuality as the identified patient, the victim is left out of the equation. The victim tends to not be recognized as an identified patient as well – as someone who is injured and suffering from the abuse and trauma. Hence, while the abuser is often getting treatment or attention, the victim is often not seen as someone in need. They may feel like they're the only one who's at home "holding down the fort" while they are experiencing REF, post-traumatic stress, and post-traumatic reactions and conditions.

To add further insult to injury, there is often no acknowledgment for the victim's efforts in holding down the fort during this very traumatic time. This lack of acknowledgment may then trigger other injuries such as gender wounds and may remind the victim of societal ideas about a "woman's place" – the assumption that women will carry out domestic work and responsibilities without consciousness, recognition, or gratitude.

The point here is to not overlook this dynamic when it is occurring. Name it and say it out loud so that people who are "holding down the fort mid-breakdown" feel recognized at least once, by one human being.

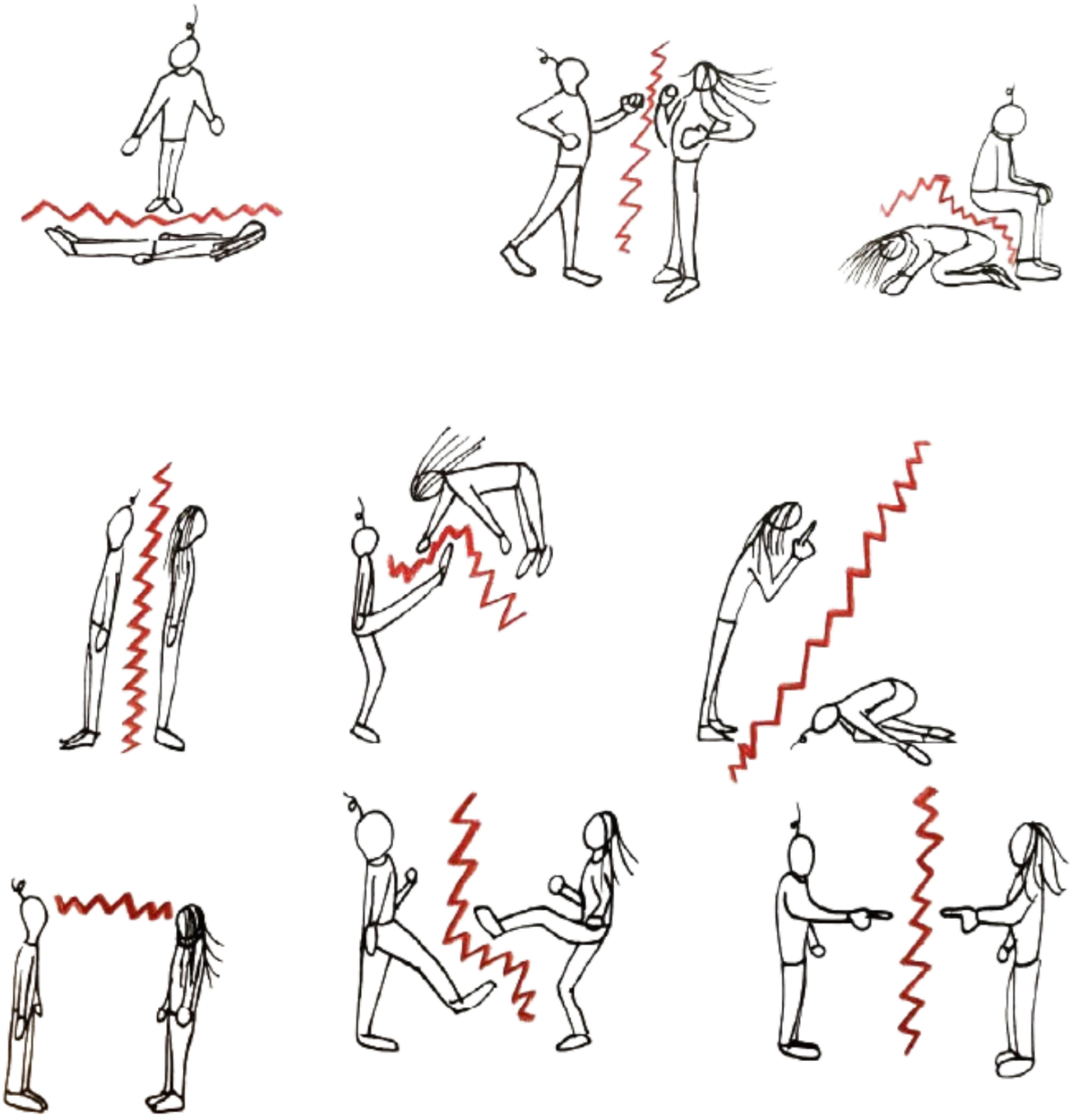


Distress and Functional Impairment

To experience reality-ego fragmentation and to experience relational rupture and attachment injury, often at the same time, can result in acute distress and functional impairment. When there is continued integrity abuse along with negative symptoms and consequences, the level of distress and impairment can persist from months to years, sometimes becoming conditions of continued complex shaping. This can include external crisis and destabilization, or the destabilization in a person's environment, on a practical level, often exacerbating or compounding trauma and overwhelm (e.g., significant changes in routines, living arrangements, alterations in family structure and co-parenting functions, allocation of resources, etc.).

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Have you or your partner experienced significant distress or impairment in any of the following:

a. Primary Intimate Relational Functioning
b. Family Functioning
c. Community Functioning
d. Social Functioning
e. Public Functioning
f. Occupational-Economic Functioning
g. Sexuality, Gender, and Body Image
h. Medical Functioning
i. Treatment Injuries and Institutional Betrayal
j. Existential and Spiritual Impacts and Functioning



How has DCSR in your partner's life caused external crises and practical destabilization to their life, routines, life functioning, etc.?

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WTF

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Room 14

Room 14: Dissociative Symptoms

The major characteristic of all dissociative phenomena involves a detachment from reality and pain.

Dissociative Symptoms

Dissociation includes a wide array of experiences and exists on a continuum ranging from mild emotional detachment, or not being present, to a more severe disconnection from physical and emotional experiences. Dissociation can be regarded as a coping or defense mechanism that attempts to minimize, master, or tolerate traumatic stress. It involves an externalized state that detaches from the present environment to numb or escape from present ego states or emotional experiences.

The major characteristic of all dissociative phenomena involves a detachment from reality and pain (not a loss of reality as in psychosis). More severe or symptomatic dissociation involves:

- alterations in consciousness (on a continuum)
- separate streams of consciousness, identity, and self
- dissociative amnesia or fugue states
- amnesia or hypermnesia
- transient dissociative episodes
- depersonalization (sense of the self as unreal or "just going through the motions")
- de-realization (sense of the world or reality as unreal)
- reliving traumatic experiences (through PTSD symptoms or through ruminative preoccupation)
- impacts to concentration, being present, or attention

This type of coping mechanism often creates subsequent consequences and symptoms, which negatively impact identity reconstruction and perceptions of reality, self, others, and truth, all of which are vital to healing.

According to the DSM-V (2013, p. 272): Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of one's mental processes or body (e.g. feeling as though one were in a dream); feeling a sense of unreality of self or body or of time moving slowly)

Derealization: Persistent or recurrent experiences of unhealthy of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted)

Clinical Notes

- Dissociation may be used to cope with being in an ongoing relationship with the abuser.
- Dissociation may relate to being attached to someone who is engaged in ongoing integrity abuse and deceptive sexuality-based harm.
- Technology can be used to induce dissociative states. Use of technology can develop into dependencies and hence may cause additional clinical problems.

Research and Education

According to Platt et al. (2017):

- Betrayal trauma theory proposes that dissociation reduces awareness of betrayal to protect a needed relationship
- Traumas higher in betrayal are uniquely related to both shame and dissociation compared to traumas lower in betrayal

According to Smith and Freyd (2017):

- Psychological trauma, particularly trauma involving betrayal, has been linked to health problems
- Betrayal trauma is also characterized by dissociation and difficulty remembering as victims face conflicting demands presented by a harmful but important relationship

This relates to being in a relationship where the integrity abuse is continuing, particularly during the exposure phase and immediately after the intersection of both realities for the victim. The level of dependency, vulnerability, and power gradient, or the sense of being trapped, influences how clearly the victim can see or metabolize the abuse. Dissociation may be one way of coping here, essentially induced to assist in being intimately attached and intertwined in an abusive intimate attachment-based relationship and family system. The term institutional betrayal (Smith & Freyd, 2014) refers to wrongdoings perpetrated by an institution upon individuals dependent on that institution, including failure to prevent or respond supportively to wrongdoings by individuals committed within the context of the institution.

According to Smith and Freyd (2017):

- Institutional betrayal is uniquely associated with both health problems and dissociative symptoms even when controlling for betrayal trauma exposure
- Institutional betrayal is uniquely associated with trauma related physical and mental health outcomes

Dissociative Symptoms

Symptoms of ego fragmentation among partners and spouses often include:

a. The major characteristic of all dissociative phenomena involves a detachment from reality and pain (not a loss of reality as in psychosis).
b. Reliving traumatic experiences (through PTSD symptoms or through ruminative preoccupation)
c. Impacts to concentration, being present, or attention

More severe or symptomatic dissociation involves:

a. alterations in consciousness (on a continuum)
b. separate streams of consciousness, identity, and self
c. dissociative amnesia or fugue states
d. transient dissociative episodes
e. depersonalization (sense of the self as unreal or "just going through the motions")
f. de-realization (sense of the world or reality as unreal)

Additional Considerations:

1. Dissociation may be used to cope with being in an ongoing relationship with the abuser.
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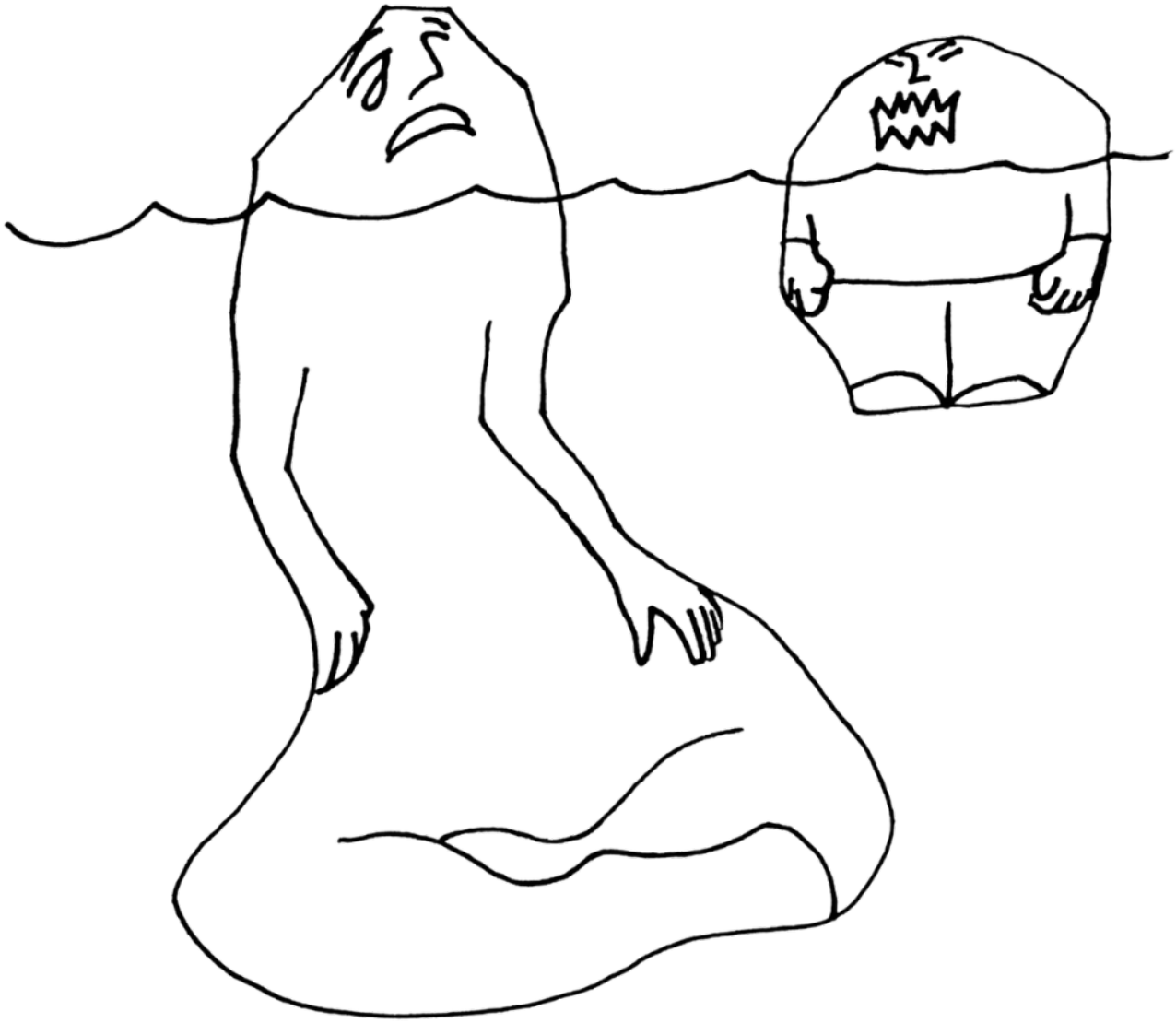

Has your partner experienced traumatic symptoms such as feeling detached or estranged from themselves, their body, or reality?

Has your partner had specific events of memories, or changes in consciousness related to your partner's trauma?

Waiting Room: Introduction to Symptom Progression Phase Abuse and Trauma

The Aftermath of Covert and Exposure Phases

After the collision of two realities and the rupture and fragmentation of the PRE, there is the symptom progression phase, which includes both short-term and long-term symptoms and consequences.

This phase is the aftermath of the covert phase and the exposure phase and involves three injury clusters:

1. Reality-ego Reconstruction Coupled with Continuation of Integrity-abuse (Rooms 15 and 16)
2. Triadic Core: Sexuality, Gender, and Body (Rooms 17, 18, 19)
3. Multiple Injured Relationships and Attachment-relational Injuries (Rooms 20, 21, 22)

It is important to note that the term symptom progression indicates the potential for symptoms to be stabilized, to get better, and to progress toward health. On the other hand, the term always indicates the potential for symptoms to not necessarily get better, but to compound, escalate, or get worse. Time itself is often not optimally sufficient for healing and repair.

Clinical Notes

It is important to note that not all people move through all three phases in a linear or distinct manner. This is simply a model and not be used in the same way for all people. In particular, the line between the exposure phase and the symptom progression phase is not distinct, but instead is a gradually evolving experience shifting from the collision to the aftermath of a new reality.

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Room 15

Room 15: Symptom Progression Phase Integrity-abuse Shaping

Symptom Progression Phase Integrity-abuse Shaping is being subjected to continued integrity-abuse patterns and conditions post covert phase and exposure phase and hence further complicates, escalates, injures, and harms the person and relationship(s).

Symptom Progression Phase Integrity-abuse Shaping

Symptom progression phase integrity-abuse shaping refers to the integrity abuse that occurs during the symptom progression phase of DST, the short-term and long-term impacts, and symptoms in the aftermath of the covert and exposure phases, as well as core wounds related to sexuality, gender, and the post-fragmentation reconstruction processes of ego, self, and reality. When abusers are caught and exposed, this does not necessarily mean that the integrity abuse stops. During the progression phase, we might see the following behaviors arise (some of which started in the covert or exposure phases):

1. violations of agreements or commitments
2. inability or unwillingness to be accountable
3. refusal to participate in repair or healing
4. inability to provide valuable care and support
5. pathologizing victims' reactions
6. demands that victim get over it and move on
7. sexual entitlement and demands
8. psychological manipulation and gaslighting
9. lying/lying by omission
10. callous attitudes towards victims
11. assumptions and expectations of impunity
12. continued engagement in the DCSR
13. continued domination and control (covert and/or overt)

These continued abusive behaviors often cause both acute traumatic experiences and progressive, ongoing complex trauma shaping in the form of symptoms such as:

1. dissociation
2. compartmentalization
3. denial/normalization
4. reality and ego confusion and instability
5. chronic depressive disorders
6. chronic anxiety disorders
7. numbing and protective symptoms
8. physical body and medical symptoms
9. persistent negative relational patterns
10. sexuality and gender symptoms
11. learned helplessness
12. learned compliance
13. loss of faith in humanity

Victims in these situations are likely to experience ongoing symptoms related to second brain injury and enteric system confusion (i.e., an inability to be aware of and to effectively respond to one's "gut instincts"). These individuals may report an ongoing sense of confusion as well as being unsure of what to believe in or what is real. Sometimes, a DCSR emerges again in this phase – the abuser may return to their secret basement and re-engage in deception – thus, overlapping a new covert phase with the existing symptom progression phase. This compounds trauma and injuries, adding more complexity and severity to symptoms and additional harm to those involved.

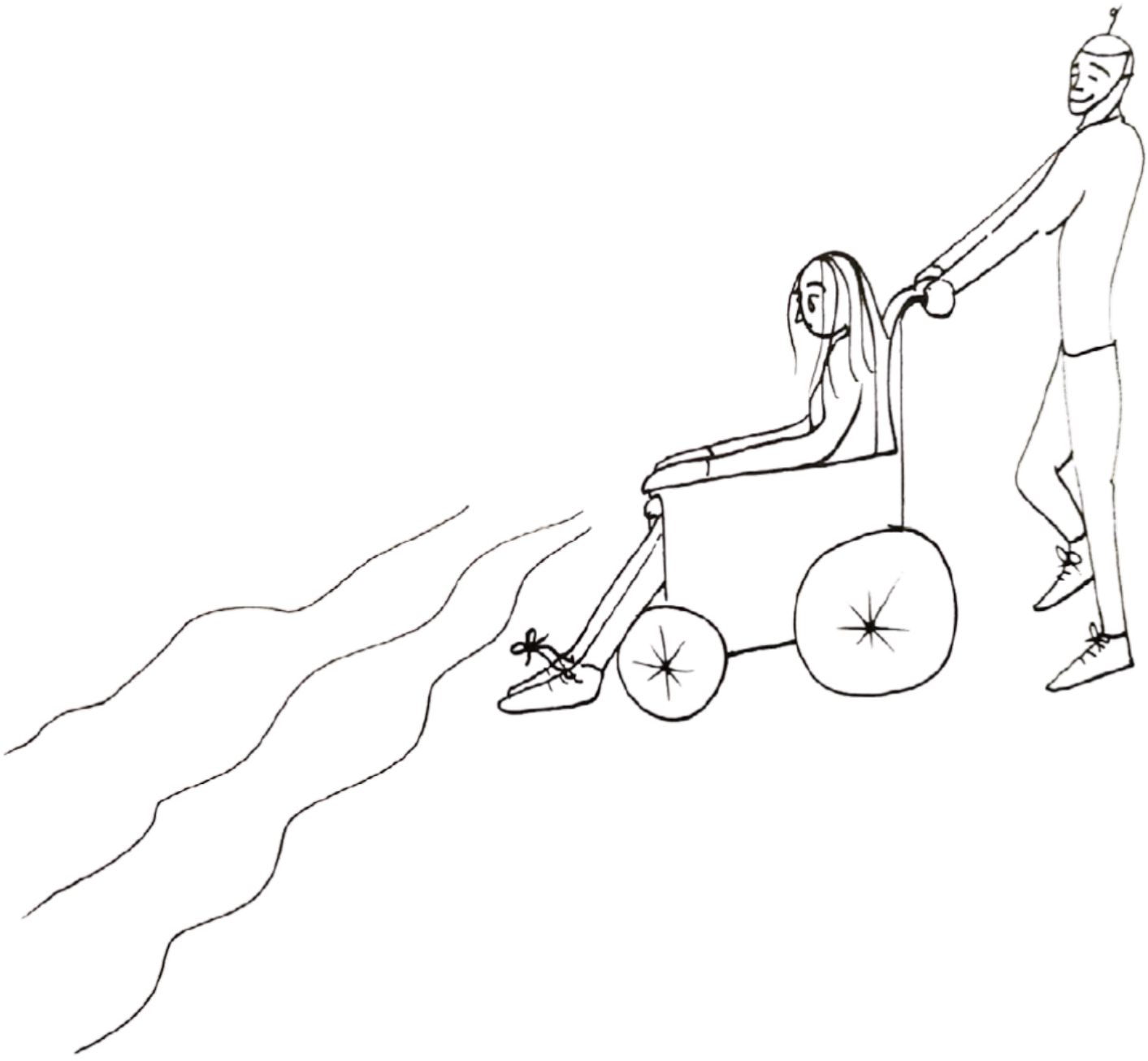
Clinical Notes

Continued integrity abuse in this phase is not exactly the same – in terms of impact and consequence – as in the other phases:

1. The continued integrity abuse in this phase gets in the way of healing, clinical support, and intervention. The ongoing integrity abuse may serve to obstruct, diminish, and interfere with the victim's healing attempts and their attempts to organize their resources toward repair. Therefore, it is important for clinicians to focus on helping to decrease and contain the integrity abuse in this phase.
2. If people – particularly those who are caring for the abuser – do not see the deceptive sexuality and ongoing integrity abuse as abuse, they will likely respond in ways that may be callous, clumsy, and insensitive – by default. It is particularly important for those working with the abuser to help them recognize the abuse.
3. It is important to account for both the covert phase abuse and the exposure phase abuse in understanding the aftermath. Many people subjected to the covert and exposure phases, including the long-term integrity abuse from both phases, are no longer the same person when they reach the symptom progression phase. The survivor of this type of abuse and trauma has been already subjected to much harm and thus is no mood for anymore. This means there is likely much less tolerance or bandwidth for any maltreatment. Now knowing more, the survivor may have newly developed and more forceful and decisive actions and ways of protecting themselves and their families from the integrity abuse.
4. The continued integrity abuse at this stage may also be particularly wounding to the relationship, attachment, and attempts to rebuild trust or to facilitate healing from the PTSD and complex trauma shaping.

Symptom progression phase integrity-abuse

When abusers are caught and exposed, the integrity abuse does not necessarily stop. In fact, harmful integrity-abuse behaviors such as deception and manipulation that occur during the exposure phase typically continue into the symptom progression phase.



Educational Metaphor: "Kicking someone in the legs while they are in a wheelchair post hospital."

What patterns of continued abuse exist for your partner now, or happened for your partner in this aftermath phase and how is it shaping your partner?

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Room 16

Room 16: Reality-ego Injuries and Reconstruction

A new structure and foundation must emerge on which to attempt to build a different reality and self must be built to survive. Thus, this is the aftermath of REF, post-tsunami. During this phase, people will experience processes related to the reconstruction of the self, core identity, and global reality.

Reality-ego Injuries and Reconstruction

Reality-ego injuries refer to symptoms and processes related to loss and grief as well as metabolizing and adjusting to REF and the reconstruction and reclamation of core functions and systems related to the post-fragmentation of identity, ego, reality, gender, sexuality, and human re-attachment and human re-connection. This may include continuing and sometimes persistent exposure phase symptoms related to post-traumatic stress due to the injury of the person's PRE and their sense of self. Both reality and self were injured in the exposure phase, and both will continue to experience symptoms for quite some time after discovery and/or disclosure.

Reconstruction represents the emerging recognition of what a new reality and a new sense of self (or ego) may mean, and the complexities involved in this type of development. During the progression phase, the fragments from the exposure phase should be metabolized to start the healing process of grieving, understanding, and making sense of a new reality. This process involves forming new, basic building blocks of cognitive assumptions of what is real or true; increasing feelings of self-worth; and improving second brain functioning. Individuals going through this process will also need to radically shift how they perceive their lives, including their universal sense of meaning. Sometimes faith in life or trust/attachment to God can rupture, causing a type of attachment injury that leads to psychic destabilization of the brain functioning.

As victims metabolize each fragment, they likely will reexperience several stress-related symptoms that impact their emotions, thought systems, and relationships, as well as their sense of self, the perceptions of their partners, and their understanding of reality. In addition, as victims digest this material, they may make new realizations and connections between the PRE and DCSR, thereby leading to even greater REF and more fragments to be metabolized. They may also continue to become informed of the types and the depths of deception, the tactics and schemes that were used, the ways things were covered up and hidden for so long, and more of the nuances and subtle aspects of the integrity abuse, which may be just as disturbing and difficult to digest. This creates a cycle in which re-experiencing trauma occurs in waves, as old and new fragments of the pre-existing realities are processed.

During this phase, victims are likely to experience some of the following types of alterations:

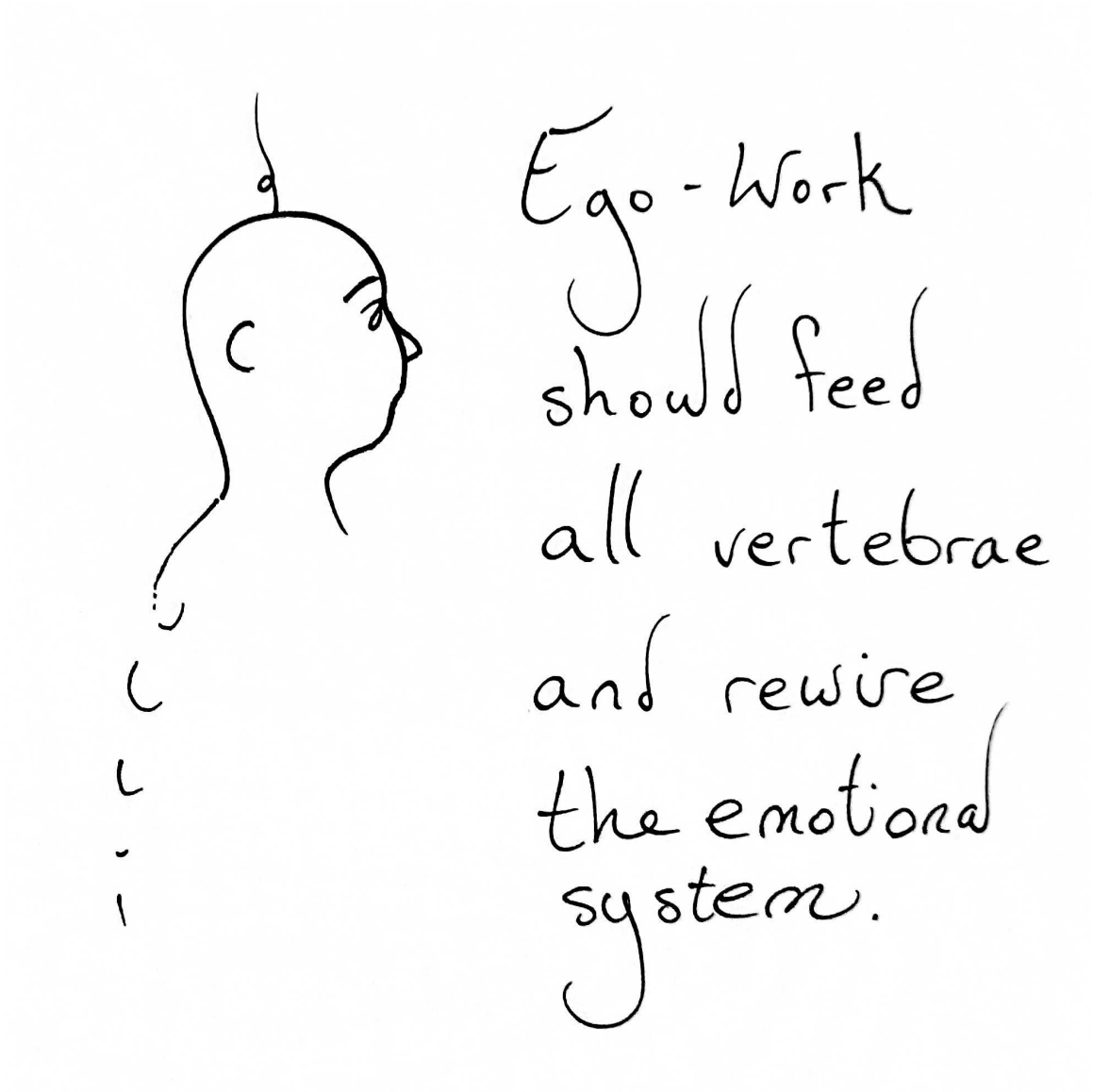
Alterations in self-perception. During this phase, victims often experience unwelcome and distressing symptomatic versions of themselves while they mourn the loss of their preexisting selves and hold out hope for a replacement version. Victims often sense that they are inhabiting a new, post-stressor self that they feel alienated from, possibly due to the ego aversion and alienation process. This process can result in confusing and/or negative ego states or experiences of the self. Alterations in self-perception include feeling helpless, paralyzed, disempowered and/or overpowered, weak, shameful, guilty, self-blaming, defiled, stigmatized, different from others, socially anxious, unworthy, feeling unattractive or sexually unappealing, alone, and/or misunderstood.

Persistent integrity abuse can make it difficult for victims to locate their fragmented selves and may rob victims of the opportunity for optimal, healthy self-reconstruction. Victims in this type of situation may become further symptomatic, feel disempowered, and experience additional, fragmented sub-selves that fluctuate over time. There may be a sense of social stigma or contamination that impacts victims' self-perceptions, and a sense of victimization may become fused with self-reconstruction.

Alterations in partner-perception. During the symptom progression phase, victims may experience both a loss and a replacement of their partners. They have lost their pre-DCSR partners and must come to terms with new perceptions of their partners that may be quite different, unwelcome, and unsettling. Integrating perceptions of PRE partners with symptom progression phase partners is often an unwelcome, distressing, and aversive process. In many ways, the partner who emerges during the progression phase may seem like a frightening and threatening stranger, a person that may not be recognizable. Partners may use words such as "monster" or "imposter" to describe their abusers. On the other hand, victims may come to see their partners as malicious, deficient, immature, pathological, sick, and/or pathetic, or they may attribute power to the abuser.

Attributions like these may be distorted and misaligned with reality because they are generated through a filter of harm, pain, disbelief, and anger. Attributions made from this space often focus intensely (and sometimes exclusively) on the negative features of the person who caused the harm and pain. During the symptom progression phase, abusers may also be providing ongoing examples of these negative characteristics, resulting in additional confirmation to victims that their altered perceptions are accurate.

Alterations in reality-perception. DST victims experience a loss of their previous realities, a difficult grieving process, and an often unwelcome, distressing, and aversive integration process. During the symptom progression phase, victims will become progressively more aware of their new realities. They will need to take time to metabolize all the new information, thoughts, and feelings and to reconstruct a new sense of reality with a sense of strength or stability. As the person metabolizes the fragments of the PRE, however, new information gets absorbed, resulting in continued symptoms of REF, often distressing episodic re-experiencing, and perceptions of the world as dark, negative, sick, toxic, dangerous, and deceptive. This can result in chronic depression, anxiety disorders, and/or physical symptoms.



Educational Metaphor #1: Post-Tsunami Reconstruction of a House

How are you supporting or obstructing the following post-tsunami (and post-DST) victim needs? Are there concrete goals you can generate based in these reflections?

1. An immediate go-to person to help pull them out of the high waters and rescue them from drowning.

2. An immediate, temporary safety net. Clinically, the more support and immediate human resources can surround the person the better. Whether the resources are all useful or helpful will and can be determined by each survivor, but the options are lifesaving here (versus the harsh reality for some, which is little to no sense of an immediate safety net).

3. Clearing space. There is a psycho-emotional need to sort and clear, which includes a process of seeing what may be kept, used, and thrown away. This is a unique and personal process of sorting through fragments of reality and making decisions related to the future. There is also a type of grieving process that occurs with sorting and clearing.

4. Regulation of trauma (swimming and surfing). People learn how to cope with the tidal waves and aftershocks that still threaten their survival. Resources, support, solid ground, safety, and reassurance as well as human connection are key here to help stabilize the victim.

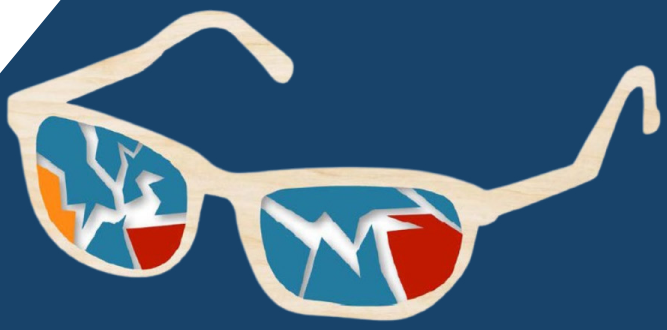
5. Level/solid ground. Solid ground is critical in the reconstruction of a house. Solid ground for victims of DST means truth. Reality and truth are the antidote to the waves and chaos of confusion that is the DCSR.

6. Supportive relationships that are high in relational integrity provide stabilization and grounding. The DCSR is a system of misinformation, denial, and deception of the self and reality. The rushing waves of the tsunami represent the DCSR. Accurate and authentic information will heal these chaotic systems, so anything of that material and vibration carries a high potential for stabilization.

7. Tools, plans, and resources for building. Once solid ground is found, one can start to build, but often the next step requires good planning and a blueprint, as well as materials and equipment. Of course, many victims do not have these resources – many do not even have people around them who will recognize the fragmentation or abuse. So, the harsh truth here is that since the tsunami is not really seen or understood, there exists a startling lack of resources for survivors.

8. Quality foundational materials. If the structure of the building is built using substandard, weakened, or damaged materials, then the new structure will rest on a weakened or compromise foundation. The task of rebuilding must go on – as an imperative survival need – but the materials are important. For example, the thoughts and psychology of someone in a highly victimized state are not the best materials to use for the foundation of the new self. These materials are likely to cause problems in the future.

When a DST victim needs the types of help noted in this metaphor (especially related to stabilization and grounding), integrity abuse will get in the way and diminish the likelihood that they will receive what they need. There is a paramount need for reconstruction of a new self (post-tsunami), which is negatively impacted by the abuser's continued integrity abuse at this critical stage of healing potential.



Educational Metaphor: Deceptive Sexuality Abuse and Trauma Glasses

Deceptive sexuality abuse and trauma glasses alter the perceptions of a person's reality and, hence, their psyche. Further, with defensive and continued integrity abuse, alterations in understanding the new self, the new relationship, and the new reality become even more confusing and threatening.

Second Symptom Progression Phase Injury Cluster: The Three Most Sensitive Tissues in the Human Psyche

Notice: You are entering an Intensive Care Unit (ICU)

The Three Most Sensitive Tissues in the Human Psyche

1. Sexuality and Sexual Self
2. Gender and Gender-Esteem
3. Biology and Physical Body

Primary Issues in the ICU

- Overlap of the triadic template (sex, body, gender)
- Core and central to the psyche and identity
- A nucleus of identity and self (yolk of an egg)
- A vertebrae of psychological health
- Conscious and unconscious management from injury

Triadic Core of Identity: Part of the Yolk of the Psychological Egg

- This section attends to one of the most sensitive areas in the human psyche according to the DST Model – sexuality, gender, and the physical body
- While these aspects of the human psyche are separate, there is an area where these may overlap – where sexuality impacts gender, and where they both impact the psychological relationship to the physical body. This triadic core is part of the yolk of the egg – a core and sensitive aspect of our identity, esteem, and worth, which is central to ego construction
- This core is like a vertebra of psychological health – not a side issue or limb, but a vital and necessary part of psychological health.
- This core is often extremely vulnerable to external social harm, injury, and insult (including social exposure and shame).
- Humans are often consciously and unconsciously protecting and managing this vulnerability and potential threat.
- For girls and women, this is the area that is often exploited – socialization often attempts to define the worth of the feminine as this area (the triadic core) at the expense of the whole person – the objectification and dehumanization of girls and women, which is one of our social mutations.
- Health in one's sexuality may increase health in one's gender and in one's body. For example, feeling good about your body naturally makes you feel sexier and more confident (notice the overlap of these three tissues of the human psyche).

Clinical Observation

Men who are in treatment for deceptive sexuality problems often share deep, core wounds related to the triadic core, including genital shame, submerged sexual abuse, gender inferiority, and triadic core alienation and dehumanization. Core sexuality issues; body shame; gender shame, insecurities, and deflation; and inferiority and wounds in this area may be one part of the person that seeks engagement and healing. And these may be some of the issues that fuel secret sexual basements – which themselves then turn right around and injure and wound victims in this very area.

Deceptive sexuality often goes directly to the most sensitive tissues of the victim's psyche – their triadic core – where their sexuality, gender, and body come together and form a nucleus of core identity that provides (when healthy) stabilization, wholeness, and integration. Deceptive sexuality often injuries the triadic core of the victim, deeply impacting their sexual esteem, their gender identity and esteem, and their body-esteem and comfort. Wounds in this area impact humans deeply – sometimes just one incident of trauma or harm can last a lifetime, causing the person to mobilize to prevent re-injury. So, these wounds cut deep. Also, because one of our collective shaping symptoms is to not understand or see gender and sexuality shaping very clearly yet, most of us are not educated about the triadic core and its importance for our psychological and relational health.

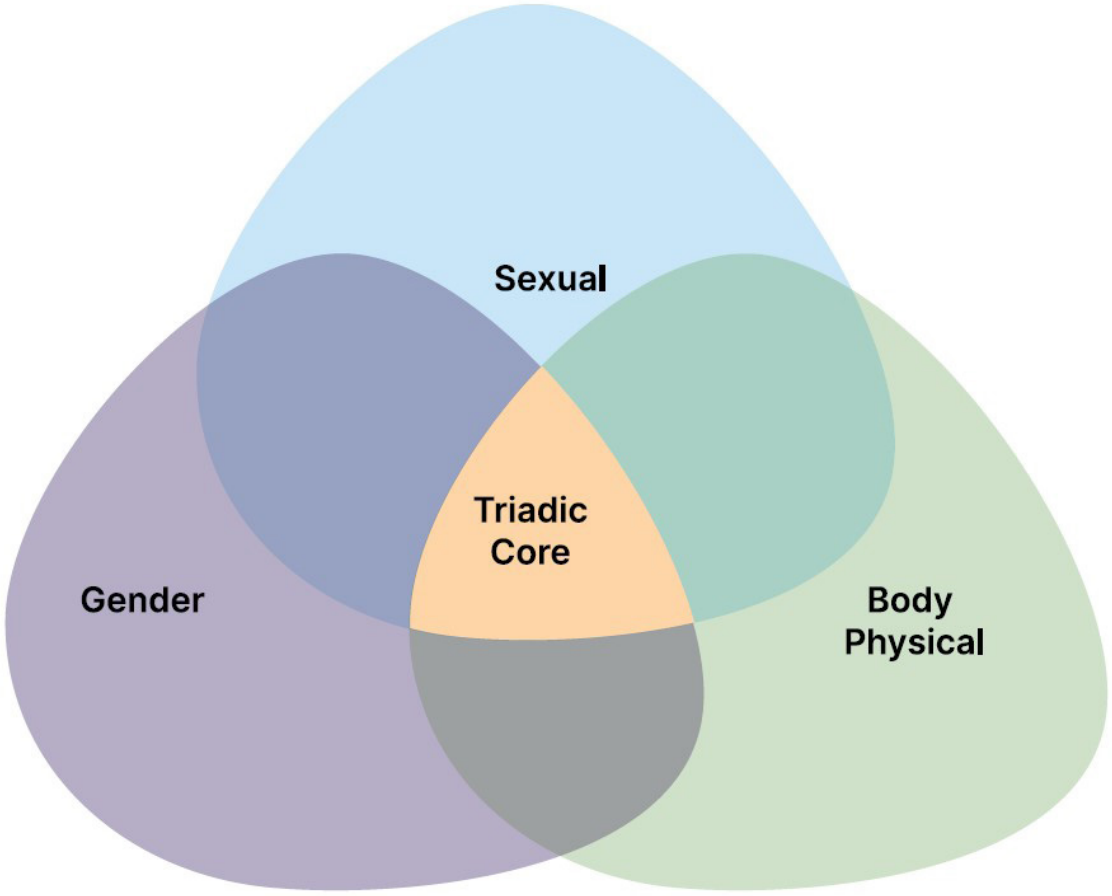
This ward includes 3 main rooms:

1. Persistent Negative Relational Patterns
2. Family, Community, and Social Injuries
3. Treatment-Induced Trauma

They all relate to the theme of negative or injurious relational alterations, injuries of various types of attachment relationships and various forms of safety nets that people's psyche often rely and depend upon for stability in life, as "they walk the tightrope of life." While the DST Model recognizes the profound attachment injury in the primary intimate partnership or marriage, it also recognizes the other types of attachments that are negatively impacted as well as other sources of pain and symptoms that may occur. Obviously, for example, if anyone harms or negatively impacts a person's child, this will often also impact the parent. In addition, the survivor may also experience relational injures and wounds related to family socializing, being in public, relating to God, etc. – essentially altering the person's human landscape and the working of their safety-net functions in life that helped to keep them stable.

Triadic Core: Three Most Sensitive Tissues

The Most Sensitive Tissues of Psyche include an overlap of templates related to Sex-Gender-Body Triadic Core of Identity and Central Vertebrae of the Psyche



Three Most Sensitive Tissues of the Human Psyche

- Overlap Triadic Template (Sex, Body, Gender)
- Core and Central in the Psyche
- A Nucleus of Identity and Self (Yolk of an Egg)
- A Vertebrae of Psychological Health
- Conscious and Unconscious Management from Injury
- Related to DST

Sexual Arousal Template - The sexual arousal of the person and the psyche as a template of habitual and ongoing patterns of specific characteristics related to sexual arousal.

Reality-ego Injuries and Reconstruction

During this phase, there may be symptoms and processes related to loss, grief, metabolizing, and adjusting to reality-ego fragmentation (REF) and the emerging recognition of what a new reality and a new sense of self. A new structure and foundation must emerge on which to attempt to build a different reality and self. Thus, this is the aftermath of REF. During this phase, people will experience processes related to the reconstruction of the self and of global reality, from basic building blocks of cognitive assumptions about what is real or true to feelings of self-worth to continued second brain confusion and recalibration.

Reality

There may also be a global shift in how a person sees life, their meaning of life, and more existential – sometimes religious or faith-based – perceptions. Sometimes a person's religious views, their faith in life, or their trust or attachment to God can rupture, representing a type of attachment injury with psychic destabilization.

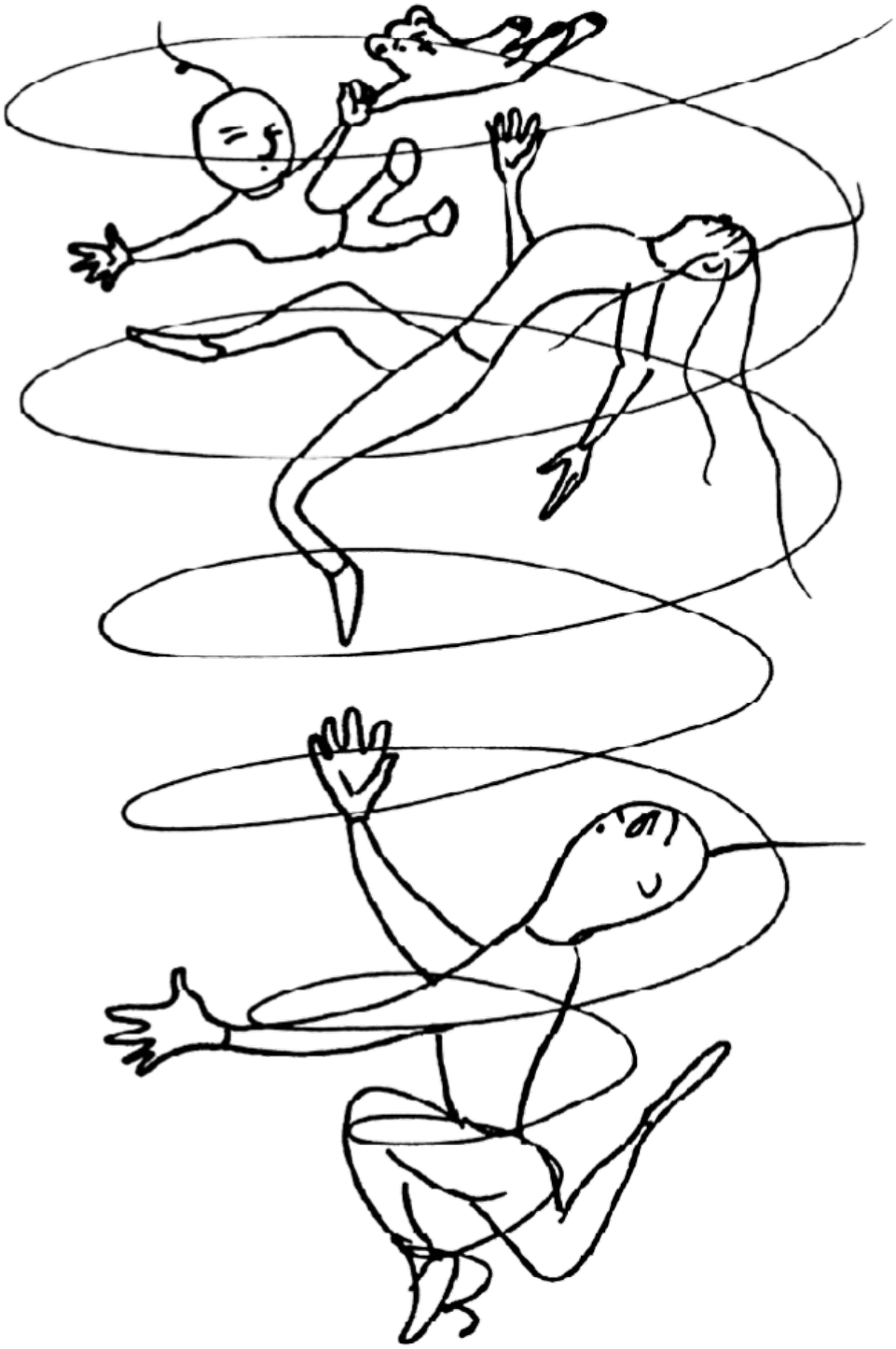
1. Alterations in perceptions of abuser
2. Alterations of perceptions of the relationship
3. Alterations in attachment, safety net and go-to person function
4. Alterations in self-perception, self-esteem, self-contact, and cohesion

Needs and Interventions to Facilitate Reality-Ego Stabilization:

- **a.** Safe space
- **b.** Solid ground
- **c.** Blueprint
- **d.** Resources and help
- **e.** Healthy cement
- **f.** Building blocks – make conscious
- **g.** Reclaim parts of self still alive and useful
- **h.** Grief and process loss – funeral prep and ceremony

Ego Injuries and Reconstruction:

- **a.** Self (Ego) has experienced harm in all three phases of DST
- **b.** Ego Aversion
- **c.** Ego Alienation or Fragmented
- **d.** Self-loathing
- **e.** Self-blame
- **f.** Self-harm
- **g.** Relationship with self, self-contact and cohesion
- **h.** Self-esteem and worth, many facets
- **i.** Hurting other people or relationships and feeling pain, guilt, or regret about doing so
- **j.** Feeling out of control
- **k.** Medical and physical health problems
- **l.** Over time, profound exhaustion, and periods of collapse of self



How is the reconstruction of your partner's identity, and their reality in the aftermath, going for them?
How has your partner's sexuality-gender-physical body, their triadic core, been impacted by DST?
What is the life story of their triadic core?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

1. CA Exercise and Working Out: Exercising the Muscle of Communicating Authentically (CA)
2. Narrate in Writing Exercise: Write or journal the story of what happened here, what you did, for your own reflection and study.
3. Right Brain Exercise: Drawn this room as it exists in AVT-ER; this Specific Behavior; or Dynamic (no words and letters); honest right brain expression for self-metabolization (ISH)
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WTF

Important: Always notice your thoughts, certainly must become aware of your emotions, and then particularly your responses and defenses, **and circle or identify those**, because those are your golden nuggets from your hard work, made more conscious for your continued metabolization, integration and growth.

What's Your Plan Man?

Important: Any Actions to Integrate to Your Work Plan and Practice?

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Room 17

Room 17: Sexuality Symptoms and Functioning

Sexuality Symptoms and Functioning refer to the impacts to your sexuality.

Sexuality Symptoms and Functioning

After the exposure shock and acute symptoms post-exposure to sexuality (Minwalla, 2006, 2011), there may be ongoing and emerging symptoms related to alterations in sexual functioning and core sexuality-related dynamics. The sexual symptoms and functioning of partners impacted by deceptive sexuality are often like those for women who have been raped or sexually traumatized (Minwalla, 2006). As noted in Minwalla (2006, 2011), partners may experience:

Sexual aversion, sexual shut down, and sexual constriction as a form of surviving and attempting to protect against the perpetrator. There can be months or years of avoiding sexuality with one's partner.

Intrusive and disturbing thoughts and images that make sexuality, including attempting to be sexual, a challenge. Specific images of the DCSR, specific sexual positions or places, and specific ways that the partner may react all may trigger re-experiencing reactions that can interfere with sexuality. There may be symptoms that impact a person's sense of sexuality as "being dirty and feeling contaminated" due to DST.

Anxiety about the possibility of having contracted a sexually transmitted disease (STD) or sexually transmitted infection (STI). Such infections sometimes lead to the loss of pregnancies or induced abortions and other serious gynecological trauma and physical consequences. Some people find the medical experience of being tested for an STD or STI, in this context of abuse and trauma, a humiliating or distressing scenario.

Hypersexual, compulsive, and/or medicating sexual behaviors. Hypersexuality may often be a survival "fight response," which may occur in the exposure phase, but can continue or emerge in the progression phase. These hypersexual reactions can be primal attempts at sexual and gender confirmation, finding control in a context of traumatic lack of control, a survival reaction related to attachment, a way of reclaiming a sense of control, etc. Some may also engage in obligatory sexuality and psychological constructs and self-generated attempts to please and meet perceived sexual demands (e.g., increasing sexual frequency, expanding boundaries, etc.). Individuals who present with hypersexuality and/or obligatory sexuality often report feelings of regret, guilt, shame, disgust, and sexual fragmentation, which in turn lead to even more trauma-related symptoms (e.g., around sexual self-esteem; negative schemas and emotional shaping associated with systems of sexual and gender domination, control, etc.).

Body image issues. Victims may experience body image issues, including feeling self-conscious, feeling sexually unattractive, or feeling competitive with others to affirm one's sexual or gender esteem and identity. Sometimes a person may turn to plastic surgery, such as breast augmentation or vulvar tightening. There may sometimes then be regret and a feeling of shame or further wounding at having had this type of surgery under such circumstances.

Important Clinical Notes

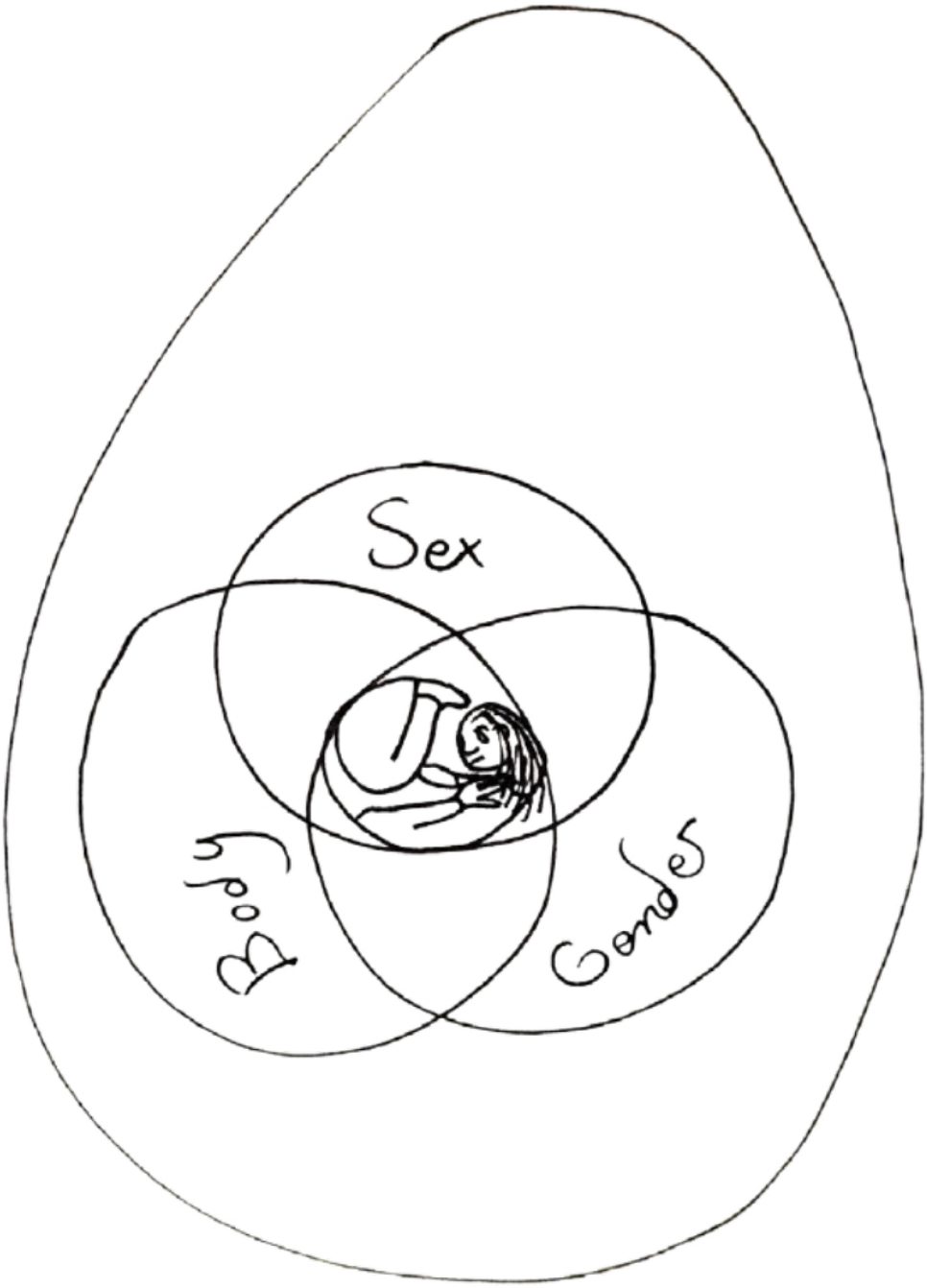
- Compulsive-entitled sexuality (CES) problems and disorders most commonly do not include sexual offending. However, sometimes CES does include sexual offending behaviors, which are sexual behaviors that lack consent, including marital rape. Some partners are raped as an ongoing system of sexual domination and violation. In response, dissociation, and detachment during or around sexuality often become a vital coping strategy. In such cases, symptoms of rape trauma syndrome (RTS) likely emerge and will require careful, conscious clinical treatment.
- Complex sexuality trauma shaping often results in people becoming fearful, lacking accurate information related to sexuality, pathologizing, attacking and judging sexuality. The socialization of rape culture and sexual abuse of girls and women creates a "rock that has been shaped" – a set of feelings, thoughts, and beliefs (i.e., personality) that are mutated with respect to sexuality. This adds complexity to any sexual injuries and sexuality wounds related to DST.
- The lack of consent and feeling of triadic core violation is very important to be aware of when approaching people experiencing this type of abuse and injury. While DST is obviously very different than rape, the sexuality of a DST victim is often impacted in ways that are like the effects of sexual traumas such as rape. In fact, the sexual symptoms that partners often experience such as fear of sex, feeling dirty and contaminated, pain during sexual activity, hyper-alertness, and humiliation and shame, blaming of body, sexual self, etc., may match some of the symptoms of Rape Trauma Syndrome (RTS; Burgess & Holmstrom, 1974, 1976, 1979; Minwalla, 2009).

Sexuality Symptoms

Sexual symptoms refer to the various types of wounds to a person's sexuality, sexual esteem, sense of safety sexually, and overall sexual functioning. This can include symptoms such as hyper-sexuality, sexual shutting-down and avoidance, intrusive sexual images and triggers, fear of disease, fear of sexuality, discomfort being seen naked by the abuser, recoil to touch or advancements toward the physical body, forcing sex on the abuser, etc.

The potential impacts of DST on a partner's sexuality may include:

- avoidance or lack of interest in sex
- sexual shutting down
- collapse and numbing
- hypersexuality as a survival fight response
- somatic genital and sexual symptoms (e.g., Vaginismus, vulvic pain and reproductive impacts) sexual traumatic constrictions
- fear and panic about having contracted a sexually transmitted disease or infection
- psychological sense of "being dirty and feeling contaminated"
- feelings of self-blame
- impulse to hide in context of shame
- fear and anxiety when reminded of sexual DST intrusions
- aversion to touch, physical holding, physical contact, and sexual activity (sometimes with any human being and sometimes more specific to the perpetrator)



How has your partner's sexuality been impacted by deceptive sexuality?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

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Room 18

Room 18: Gender Wounds and Symptoms

Gender Wounds and Symptoms refer to the impacts to your sense of gender and gender health.

Gender Wounds and Symptoms

Secret sexual basements are built more often by men than women and cause more damage to women and children than they do to men. Thus, deceptive sexuality can be considered a form of gender-based violence and a masculinity problem and pathology.

One obvious and immediate wound comes from the fact that this type of violence is not really recognized yet. Male sexual entitlement continues to go unchallenged. The abuse of male power and privilege, as a system of encouragement and esteem-status-gaining, is generally seen as a socially acceptable. And secret sexual basements are not recognized as a form of systemic abuse.

Hence, to understand the injuries in this room we must first recognize the collective injury done to women and children as a group. Women and children are part of a social order and system that places them in a "deserving role" of dehumanization and degradation. Because we do not tend to recognize this and because we do not talk about gender authentically, many victims who feel hurt and harmed may not be able to give voice to their injuries. It is only when they are put into a situation that is deeply traumatizing to their gender that they may deeply resonate, connect to previous gender abuses and wounds, and begin to attempt metabolization of these gender injuries.

Gender identity/gender esteem is a primary core dynamic in self-construction, self-esteem, and self-worth. It is foundational to our overall psychological functioning and adjustment. In a clinical system of traumatic injuries, gender identity/gender esteem is delineated to more fully appreciate and understand the traumatic wounding in service of repair and integration of regenerated gender fragments and gender esteem, along with the reconstruction of gender identity in a post-DST clinical context.

To the extent a person is subjected to gender pathology, they will likely incur gender-based wounds, some which may be unconscious or difficult to name and describe but experienced as a form of psychic pain and suffering. Partners exposed to deceptive sexuality and integrity-abuse behaviors are often profoundly impacted at the core of their gender identity/ gender esteem (Jason & Minwalla, 2009), which often includes damage to ego structures and core gender constructs such as wife/husband, mother/father, female/male, sexual being, and worthy being. Issues and potential symptoms related to gender wounding include body image disturbances, eating disorders, and body dysmorphic reactions, to name just a few.

Important note: Feminist theorists are particularly critical of therapy practices that ignore these privileges and power differentials (Williams & Knudson-Martin, 2013)

Gender Wounds and Gender-based Trauma

This refers to the various types of wounds to a person's sense of gender, conceptualization of gender, and gender esteem. This can include alterations in perceptions of gender, men and women, low gender esteem, a compromised sense of gender roles, escalation in body image issues, processes related to oppression and victimization based on gender, etc.

Gender-Specific Alterations:

- Diminished sense of gender
- Decrease in gender-esteem
- Diminished sense of identity of gender roles (e.g., mother)
- Alterations in perceptions of gender
- Alterations in emotions related to gender (people, topic, society)

How has your partner's gender health and sense of gender been impacted by deceptive sexuality?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

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Room 19

Room 19: Physical Body and Medical Intersections

Physical Body and Medical Intersections refers to the impacts to your body.

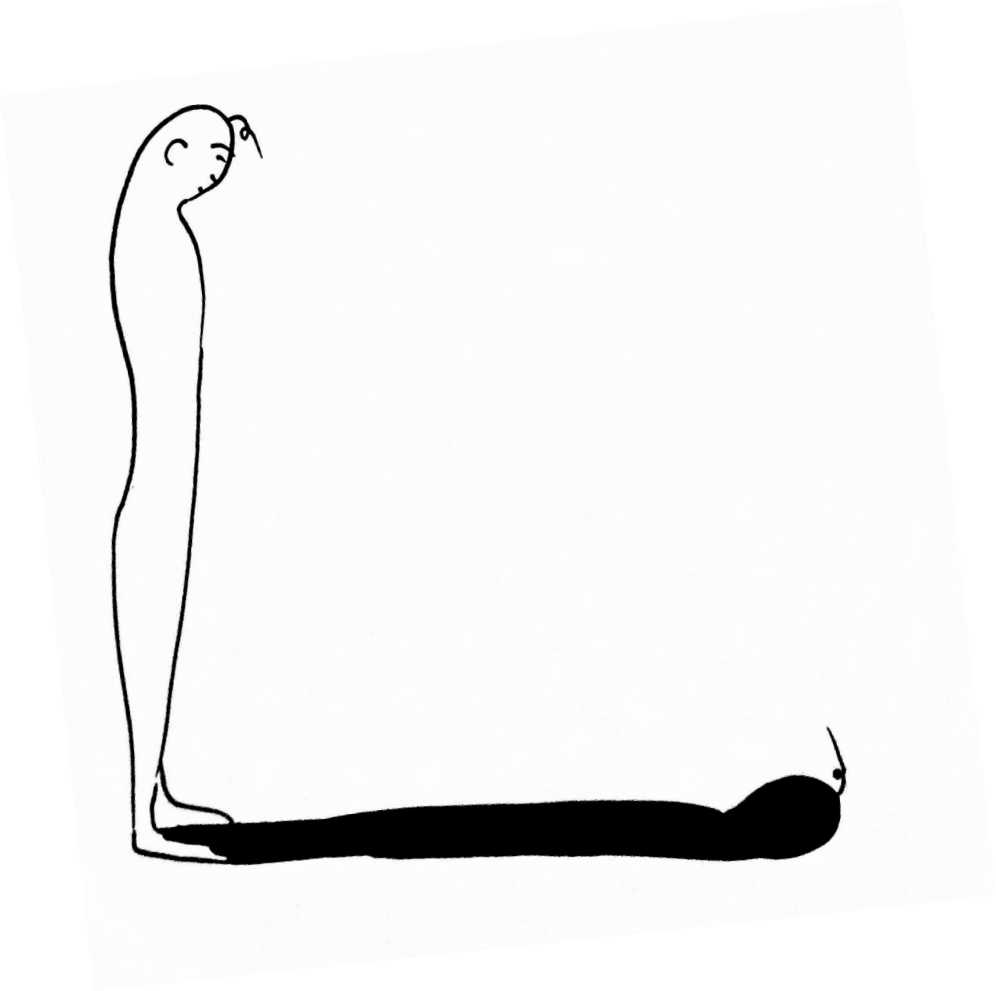
Impact to Physical Body and Medical Intersections

This refers to the impact on a person's physical body and potential medical symptoms that may occur due to being in an ongoing toxic relationship with a DCSR. This can include sexually transmitted infections and disease as well as body image issues, self-consciousness, social comparison, low body esteem and confidence, etc. These issues are likely to impact other areas of functioning and may include high levels of preoccupation and rumination.

Trauma is physical. It is neurological. It creates bodily symptoms. Hence Room 19 focuses on – and honors – the survivor's physical body and what the survivor's physical system may have endured or experienced during their journey through DST. Recognition of the physical body and encouragement of the victim to conceptualize the physical body as part of what has been impacted can be very helpful in facilitating healing. The mind-body relationship as well as the recognition that trauma can be placed in the body as part of responding and coping is critical in healing from DST.

Examples of DST Impacts to the Body:

- The interdependency of medical conditions and medical vulnerabilities with DST is critical from a clinical perspective as well as a medical perspective
- May include pregnancy, cancer and chemotherapy, prescription medication interactions, chronic pain disorders, stress disorders, eating disorders and body image concerns
- Psycho-emotional adjustment to changes in appearance, impacts of trauma on body, changes in the body, inability to use the body, and/or dependency on the body
- Body shame, changing the body and altering looks, body image wounds, body-attraction-sexiness-related preoccupation with the body, body comparisons often related the triadic core injuries
- Gut instincts as neurological damage and internal physiological detection systems that may impact physical health



How has your partner's body been impacted along this deceptive sexuality and trauma and abuse story?

Does this Metaphorical Hospital ROOM apply to you, and your story, in your AVT-ER?

Can you lift up, and get out, and express this story?

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Room 20

Room 20: Persistent Negative Relational Patterns

Persistent Negative Relational Patterns refer to the post-traumatic alterations to attachment, trust, and safety in the relationship itself, and the dysregulation and further harm that may occur.

Persistent Negative Relational Patterns

Healthy and secure attachment to human beings is essential to psychological health (Bowlby, 1979). Disconnection from human beings results in pain, dysregulation, and disease. Rupture from what was experienced as a secure attachment, which included psychological and emotional dependency, can be experienced as a critical traumatic event and process (Johnson, 1996).

Upon discovery, the abuse victim often experiences the loss of their "safety net" or "go-to person." The abusive partner also experiences the loss or rupture of a "safety net" or "go-to person," creating trauma and destabilization for them as well. This sudden and severe attachment injury is experienced by everyone involved in the relationship, even if they caused the injury to occur.

Deceptive sexuality deeply impacts the abusive partner and the victim, as well as profoundly alters the relationship as a separate, third entity. The relationship – the "us" itself – is traumatized and may become very negative, unhealthy, and toxic. To understand this, the conceptual view here must be of the relationship not as two separate people, but rather as the energy which existed and emerged between two people, forming a third and separate injured entity. The energy of this entity experiences negative impacts and changes over time, which may slowly become a form of CTS that impacts all three entities. The relational synergy is harmed, and the relational system that existed between the two people has become another casualty of the abuse.

When we have two people whose lives and relationship are forever altered from their pre-existing form, each person's preexisting attachment wounds, from birth until the present, may be activated. This complicates the conflictual instincts in each person. Partners may feel conflicted about whether to depend on or to instead defend and protect against each other based on their primal and survival instincts. These instincts can be powerful and activated concurrently, fluctuate rapidly back and forth, or evolve and change progressively over time, further shaping the injured relationship.

Most often, the abusive partner may be experiencing a type of post-traumatic stress due to relational rupture and may have inadequate and insufficient tools or maturity to deal with the trauma upon exposure. In these cases, the abusive partner is unable to recognize their participation in any type of abuse problem and may continue the integrity abuse. They may be callous, defensive, and abusive towards the intimate partner and the relationship. Their inability to take ownership, fear of the consequences, and lack of comprehension about abuse injuries and traumatic repercussions combine with their preexisting deficits and limited capacities for healthy emotional or relational responses. As a result, they may continue to perpetrate defensive and abusive reactions, which harm the partner and the relationship.

It is critical, however, to see both people in the relationship as full human beings and not objectify or dehumanize them, nor to distort reality to "protect the victim." The victim remains a human being and should not be considered a "neutral object," "non-relevant object," or any other objectification of the victim's humanity. Both people are adults who are responsible for their actions.

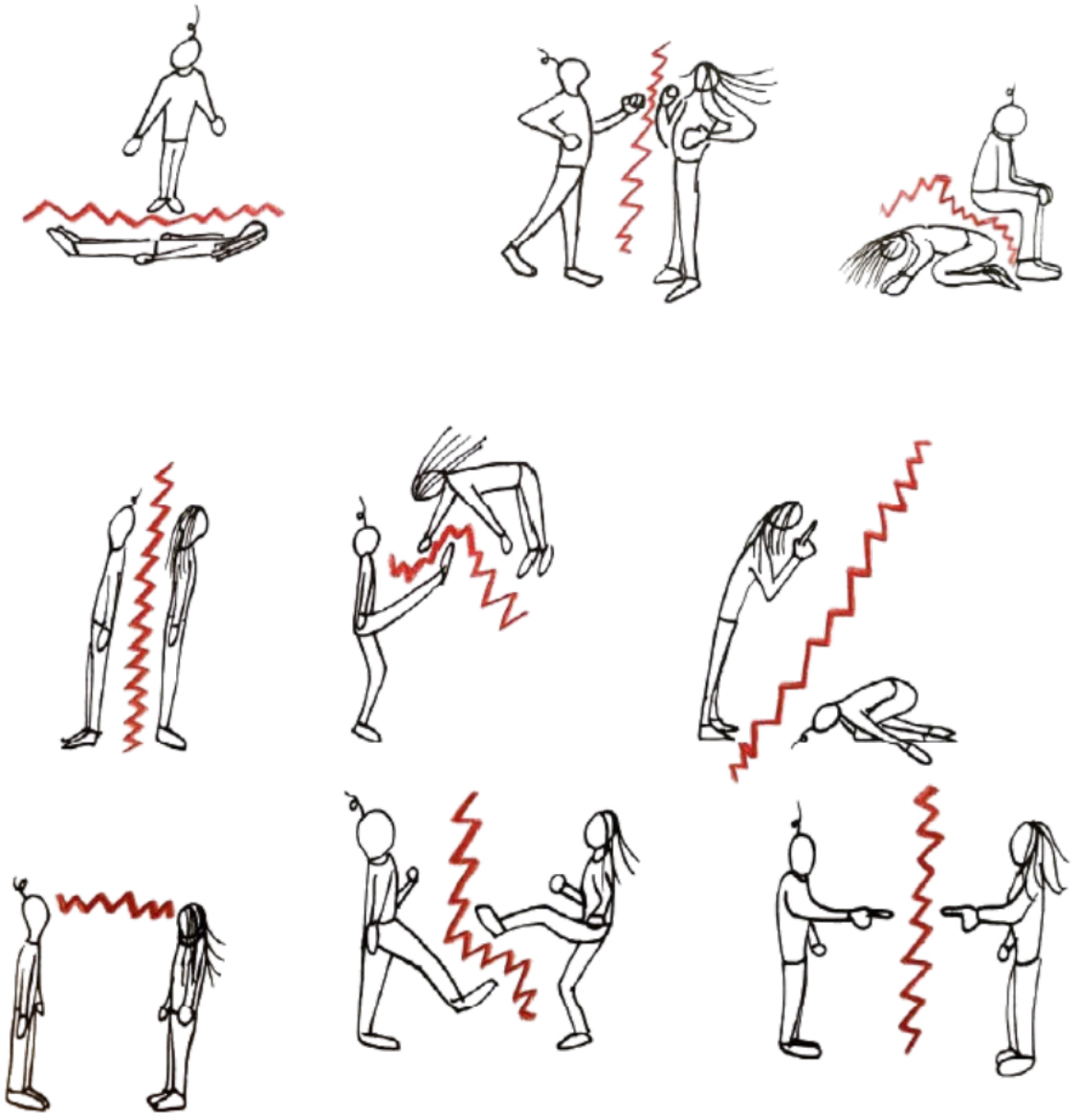
Victims who are experiencing post-traumatic reactivity, arousal, and stress symptoms caused by the subjugation to abuse may have reactions that are aggressive, violent, endangering, abusive, unhelpful, distorted, confusing, scary, and/or otherwise harmful to others and their relationships. They may experience rage, primal screams, loss of impulse control, extreme fear and hypervigilance, startle responses, high reactivity to triggers, and surges of fear and anxiety associated with re-experiencing. This post-traumatic arousal and reactivity is an expected symptom of abuse and trauma.

These common behaviors may be easily misunderstood and misapplied in ways to blame the victim. Therefore, it is critical to shine a light on one of the most common tactics used by abusive partners, which is to deflect or defend against responsibility for the abuse by pathologizing the victim's reactions and actions. The symptoms the victim experiences post-trauma are a direct result of the abuse and trauma. It is unjust, unfair, an intentional manipulation and mischaracterization of the truth, and another insidious form of integrity abuse to take advantage of a victim's post-traumatic reactivity and normal human reactions without acknowledging the cause and context of the reaction.

However, harm, abuse, and violent actions, even when stemming from abuse and trauma in the victim and as part of the natural and expected symptoms of trauma, is still harmful and will hurt others and relationships. The origin of the abuse does not diminish the harm of abuse on other human beings. Harm perpetrated by victims should be understood within the context of abuse and trauma – with integrity, empathy, and justice for the victimization always considered as important factors in maintaining perspective. This perspective should never be used to collude with the victim's abuse, violence, or harm to other human beings, nor should being a victim of harm entitle a victim to violence, perpetration, or abuse. While it may be tempting to overlook harm perpetrated by the victim to stay clear of victim-blaming, it can become a dangerous form of patronizing as well as a dehumanizing and objectifying view of the victim. Victims are responsible for post-traumatic actions that hurt others, just as the abusive partner is fully responsible for their actions that hurt others.

The relational ruptures, attachment injuries, relational disconnection, and inability to reestablish healthy or even regulatory attachment may become an additional source of traumatic experience for both partners. Both partners, for many different reasons, create defenses and triggers to each other, which result in negative relational trauma-related patterns (postexposure phase) where both people are being hurt, repeatedly, creating further detachment, human harm, and relational rupturing. These persistent negative relational patterns and their repercussions may absorb much of the energy and resources in the relationship, depleting and exhausting healing attempts. The lack of ability for reattachment may result in traumatic reactive escalation or erosion of attachment attempts and potentially lead to the eventual loss of relational stability and basic dependency.

This is precisely why building a secret sexual basement is so damaging. The eventual outcome includes a traumatized and injured relational reality, lacking in secure attachment or even basic safety or health for both partners as well as for children and the family system. Despite sincere attempts at healing, both people in the relationship are in pain and may be so reactive to each other and so overwhelmed by the prospects ahead, that they are unable to sufficiently transform the negative energy between them, and so both partners may continue to engage in persistent negative relational patterns.



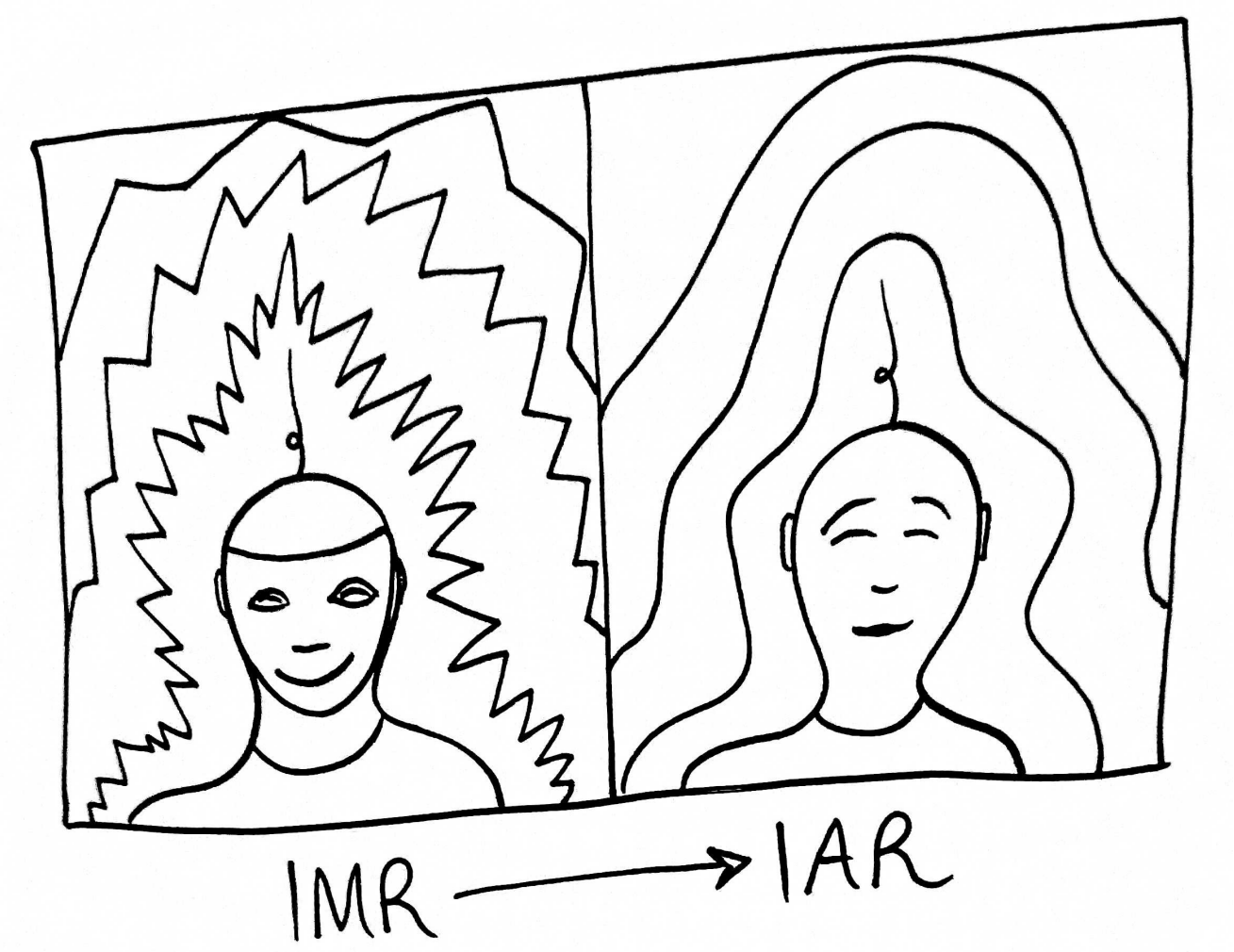
Relational Trauma and Persistent Negative Patterns

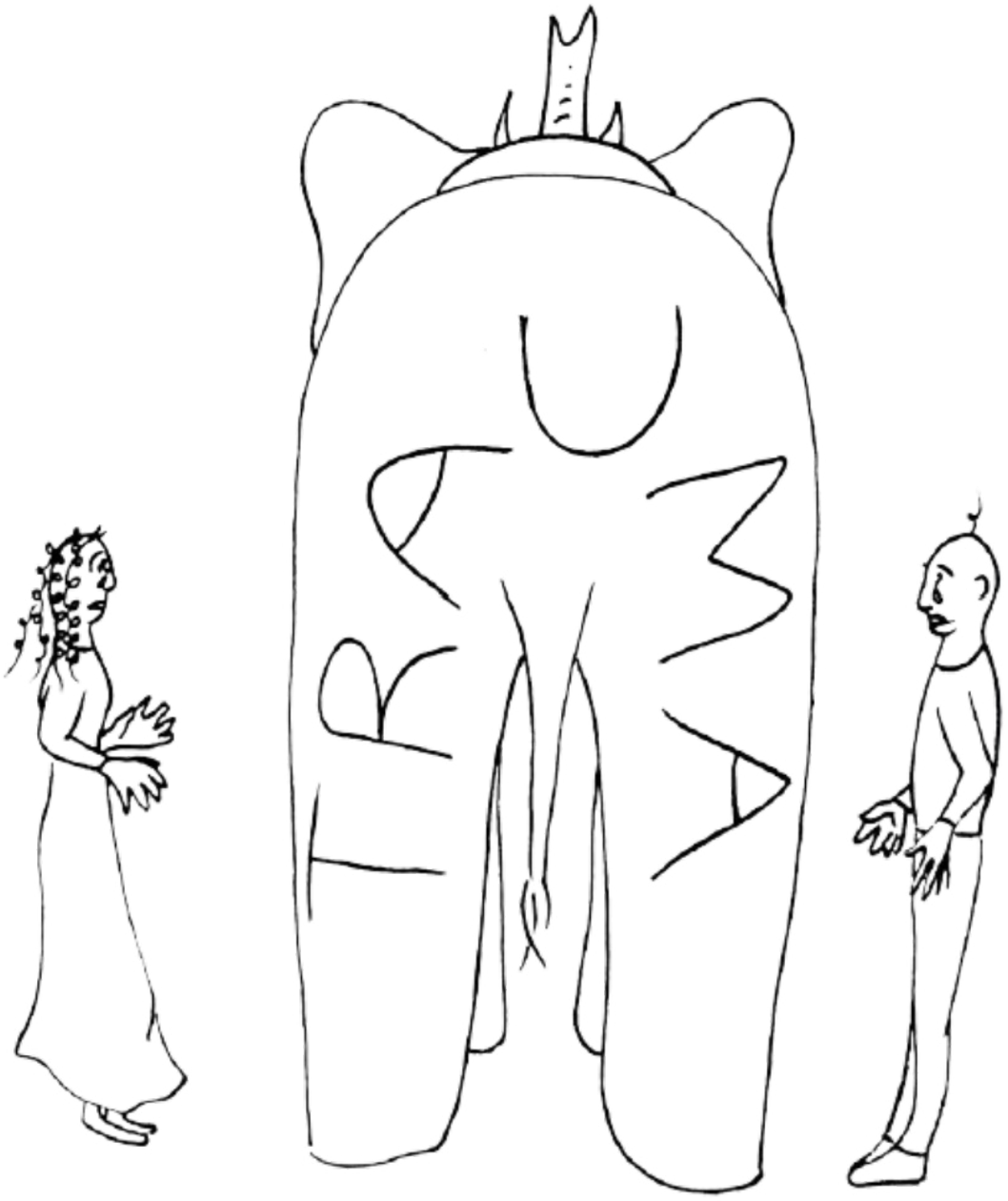
Both partners are often traumatized as a result of deceptive sexuality. This traumatization leads to defenses and triggers in both individuals, which results in negative relational trauma patterns in the couple. This then often constitutes another pattern of traumatic injury where both people are being hurt, creating further detachment and rupturing, which can eventually turn into a form of complex trauma shaping of each person and of the relationship itself.

The Relationship as a Third Separate Entity:
The second critical injury refers to the injury to the relationship, conceptualized as a separate and third entity. This injury includes relational integrity erosion, which potentially occurs during all three phases of DST, slowly eroding, corrupting, and draining the relationship bond over time, beginning in the covert phase.

The relationship then experiences relational rupture and attachment injury, which occurs upon reality-ego fragmentation (REF) and results from the sudden rupture from, and loss of attachment to, the pre-existing reality of the partner. As is the case with the first critical injury, this injury causes specific PTSD-related symptoms.

These relational experiences then naturally may progress into the persistent negative relational patterns, commonly observed in the symptom progression phase. These relational patterns are often associated with the net effects of relational integrity erosion, the net effects of the integrity abuse, and the aftermath of relational rupture and attachment injury. Thus, the relationship is subjected to these three phases of relationship-specific injury, abuse, and potential relational symptoms.





What persistent negative relational patterns exist now?

What is your role in these patterns as the abuser?

How does your Integrity and problem attending patterns play a role in these relational patterns?

Have you have realistic expectations for the relationship(s) after enduring this type of abuse and trauma?

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Room 21

Room 21: Family, Communal, and Social Injuries

Family, Communal, and Social and Existential injuries refer to the consequences on social and interpersonal functioning, which can be a significant source of trauma and may involve multiple attachment injuries, significant grief and loss over many relationships, and profound, sudden, and prolonged alterations in relating to other human beings.

Family, Communal, and Social Injuries

While trauma impacts a partner's interior world and primary adult attachment, it also has far reaching implications for other relationships, including the parent-child bond, the child(ren), the family system, the social world, the experiences of being in public, a sense of community that provides stabilization and dependency, and relationships to others in general. The consequences on social and interpersonal functioning can be a significant source of trauma and may involve multiple attachment injuries, significant grief and loss over many relationships, and profound, sudden, and prolonged alterations in relating to other human beings. These all impact the stabilizing function of having invested in a safety net and the assumption that if one falls or experiences turbulence as one walks on the tightrope of life, then one will be caught and will be safe and secure.

Often a family system is invariably impacted by deceptive sexuality. Partners may end up holding secrets from loved ones and family members. Partners may lose friends and/or may find out their friends colluded with the DCSR. The trauma may also cause social constriction and avoidance, leading to significant changes to how the partner relates to social reality, community, public space, and human beings in general (e.g., agoraphobic symptomology, loss of faith in humanity). Partners having to bear witness to profound traumatic impacts on their children, in particular, can experience specific trauma as a result. The ongoing reality of children being impacted and harmed may provoke deep instinctive reactions and biologically based protective parental instincts (e.g., mama bear, hornet's nest). Partners who see their children suffering or demonstrating symptoms due to the repercussions of deceptive sexuality often experience a significant source of traumatic re-experiencing, which induces, for example, episodes of rage.

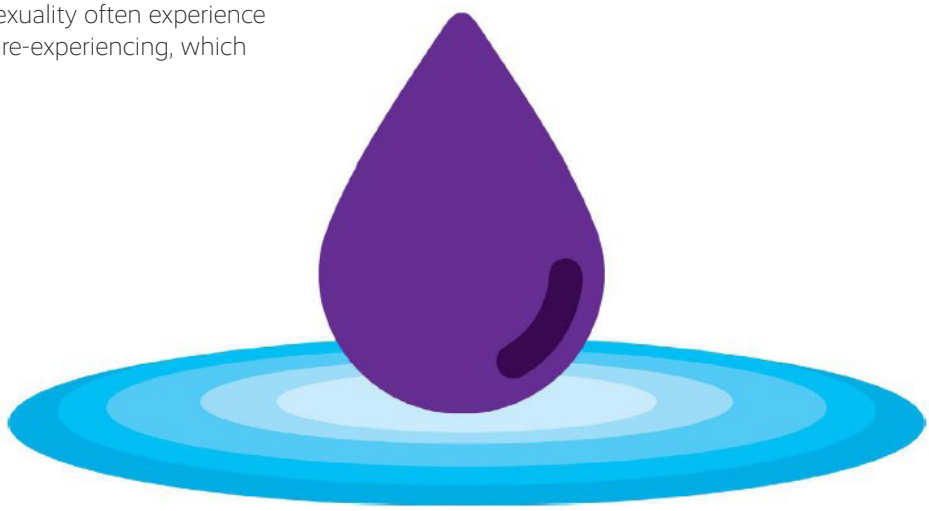
Relating to Human Beings and Attachments: Other Types of Injuries and Traumatic Symptoms as the Person Walks the Tightrope

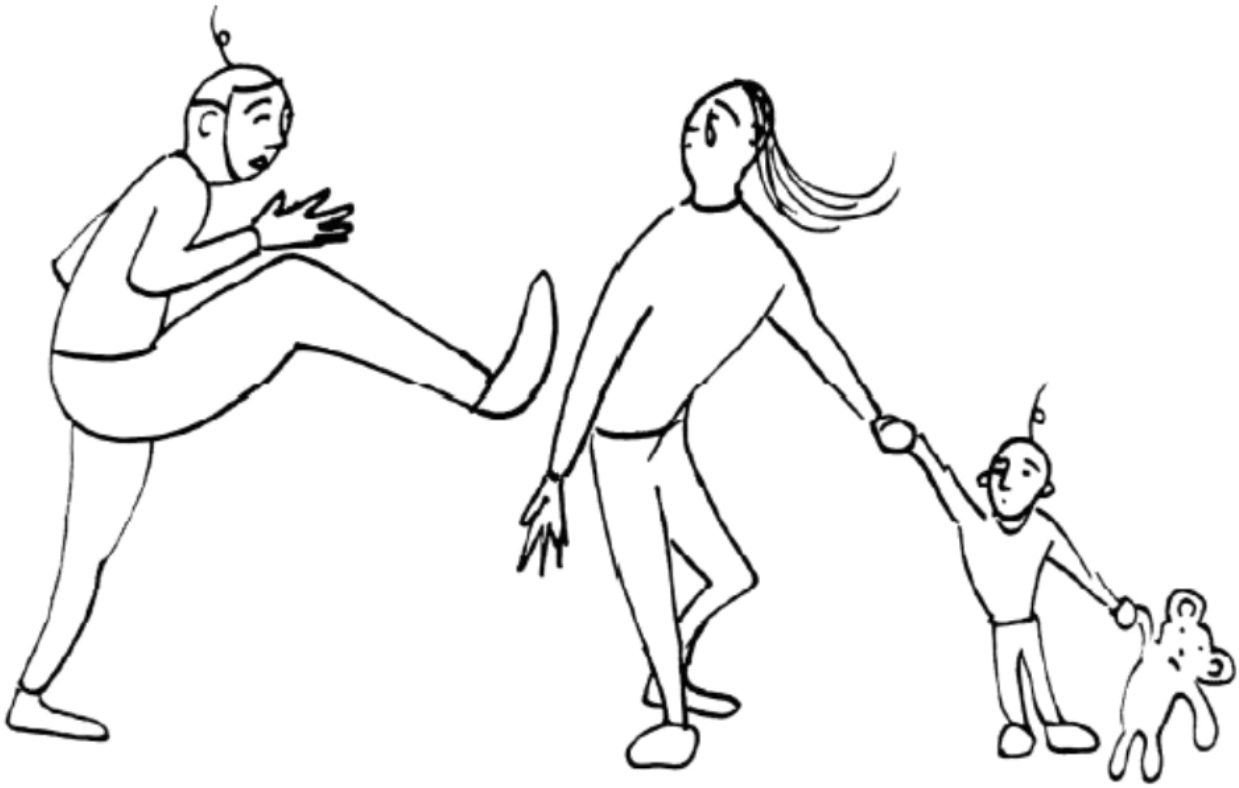
The types of injuries that occur for DST victims within the context of other attachments, outside of the intimate partnership, can be particularly wounding and destabilizing as well as cause additional and separate symptoms.

- Abuser's ego, including the triadic core (nucleus)
- Intimate relationship attachment
- Children as human beings
- Parent-child bonds and attachments
- Family system
- Extended families
- Neighborhood and social circle
- Community attachments
- Relationship to public or social spaces
- Concepts related to humans in general and faith in humanity
- Treatment-induced trauma and institutional betrayal
- Social collusion, silence, and systemic social-cultural betrayal
- Existential trauma and relationship with God, the universe, systems of meaning, etc.

Family, Communal, and Social Injuries

These types of injuries refer to other relationships (besides the intimate partner) that may be harmed by deceptive sexuality. There may be injuries experienced by children within the family system as well as impacts to the child-parent bond, the family system, the community, and more global relationships to humans in general.





What relationships have been impacted, altered, and changed due to the secret sexual basement and the relational and attachment repercussions to children, parent-child bonds, family as a sacred team, and the relationships with others outside the family, community, social functioning, and existential dynamics including a relationship with God, etc.

What impacts has your intimate partner experienced in this room?

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Room 22

Room 22: Treatment-induced Trauma

Treatment-induced Trauma refers to harm from therapy in seeking professional help or care for this type of abuse and trauma experiences. Sometimes this can cause other types of traumatic injuries and additional symptoms, related to institutional betrayal trauma and attachment injuries or failures, etc.

Treatment-induced Trauma

How and why this term was developed:
Effective clinical strategy recognizes the clinically and ethically important utilization of an abuse-victim-trauma consciousness that informs the treatment approach. The term treatment-induced trauma (Minwalla, 2012) was developed based on a grounded-theory emerging theme among partners of sex addicts, meaning that it kept showing up in clinical treatment and in qualitative research narratives as a common cluster of injuries.

The term ***treatment-induced trauma*** refers to specific wounds or harmful experiences that occur from treatment, which many partners and injured relationships may experience. Treatment-induced trauma is a clinical or medical intervention that causes harm to the patient or client. In treatment-induced trauma, traumatic consequences ensue from clinical interventions or serious clinical omissions perpetrated by therapists and medical professionals.

Here are some common traditional areas of potential clinical harm:

- Diagnostic Mislabeling: Views the spouse/partner as a co-sex addict or codependent without recognizing that the person is a victim of abuse and experiencing traumatic symptoms
- Clinical Omissions (not seeing the abuse or trauma): General and non-specialized therapy that is not aware of an abuse-victim-trauma dynamic
- Couples' work where there is an assumption that the relationship is the problem since it "takes two to tango," sometimes erroneously presented as using a "systems approach," assuming a relational "cause and responsibility" for DCSR and IAD
- Premature Sex Therapy Interventions: Interventions utilizing traditional sex therapy that encourages sexuality and intimacy with little work to address the abuse and trauma first and failing to address the abuse-victim-trauma that exists
- Various forms of victim-blaming, victim-blaming bias, relationship-blaming bias
- Various forms of collusion with the perpetrator, silence, betrayal, lack of protection
- Various forms of socialized and gender bias, including a tendency to avoid integration of gender, power, and relational injustice as a necessary part of clinical intervention
- "Cookie Cutter" Model vs. Survivor-Centered and Case-Oriented; Not considered unique

Keep in Mind:
For professionals doing clinical work with patients struggling and presenting with issues pertaining specifically to DST: If you are not seeing the abuse and trauma, then likely you will be clumsy, callous, and insensitive – by default.

Remember the American Psychological Association reminds us clearly:

- "We suggest that those involved in partner violence have special treatment needs and that those who treat them must do so with sensitivity and from a base of knowledge which comes from specialized training" (APA, 2002, p. 5)
- "Psychologists who do not have the requisite training potentially endanger their clients, and likely commit an ethical violation" (APA, 2002, p. 5)
- "Those who are teaching psychologists-to-be but who do not teach them about partner violence are abrogating their responsibility and risk perpetuating the conditions which foster this problem" (APA, 2002, p. 5)

Obviously, DST is a newly emerging concept. Much of the DST Model resides in the dark, and much of what we have learned is not yet part of the collective consciousness. Hence, it makes sense that these problems still exist in the treatment field. However, this does not erase or take away from the harsh reality of decades of institutional betrayal and specific harm, which add insult to injury and can lead to additional trauma and symptom exacerbation.

Types of Injuries and Traumatic Symptoms Related to Treatment
For victims of DST, treatment-induced trauma can be particularly wounding and destabilizing as well as cause additional, separate symptoms.

Many victims of DST are already in acute distress and experience significant symptoms specifically related to:

- Betrayal
- Gaslighting and being subjected to realities that are not accurate and do not resonate
- Social contexts where abuse is unrecognized and even encouraged
- Male entitlement and the inherit lack of introspection related to power and privilege as the dominant group
- A society and clinical world where the tendency to victim-blame is pervasive, including within institutions (e.g., legal) So, to then turn to treatment for help from these wounds and actually reexperience some of these exact injuries again may cause serious additional symptoms.

Therapeutic Attachment Injury

- To reach out for help and to be let down, let go, or hurt instead of helped is one of the most serious violations in medicine, therapy, and attachment relationships (American Psychological Association, 2010)
- This can be experienced by the patient(s) as another type of attachment injury and a specific type of relationship rupture
- The loss of the basic assumption that the therapist and the treatment itself will do no harm can be experienced as a specific type of attachment injury, which may cause additional symptoms and exacerbate attachment injuries from the exposure phase
- We know attachment injuries can be a source of trauma

Professional Caregiver Betrayal

- This injury also in it has the potential for inducing betrayal trauma as well, since there is a built-in trust in the mental health professional's role as a professional caregiver
- This can be experienced as not just an attachment rupture but also as a type of betrayal outside the family or intimate partnership
- This can often trigger past betrayals by caregivers as well as the current betrayal from the DST, all of it as one experience for the survivor
- We know betrayal from a close caregiver can cause a specific type of trauma

Institutional Betrayal

- The term institutional betrayal refers to wrongdoings perpetrated by an institution upon individuals dependent on that institution, including failure to prevent or respond supportively to wrongdoings committed by individuals within the context of the institution
- Institutional betrayal is uniquely associated with both health problems and dissociative symptoms
- We know that institutional betrayal causes a specific type of trauma

APA GUIDELINE 3: Psychologists strive to recognize, understand, and use information about structural discrimination and legacies of oppression that continue to impact the lives and psychological well-being of girls and women.

The DST Model developed from the recognition of structural discrimination stemming from the fact that existing treatment for victims of deceptive sexuality simply did not exist in a targeted manner – there is a decades-long treatment legacy of victims being treated as codependents, co-sex addicts, or part of the relational problem, all of which essentially blame the victim. This clinical, treatment-based, and professional structural discrimination is understood to exist not in a vacuum, but within a larger social context. The society at large has this same structural bias and tendency to victim-blame and to ignore/not understand the problems with victim-blaming, particularly for victims of abuse and trauma.

Victims of deceptive sexuality have endured institutional harm in additional to personal harm and injuries. They have not received adequate support from helping professionals and are pushing against powerful forces that do not understand or even see them clearly. The DST Model was developed in response to the structural discrimination experienced by victims of deceptive sexuality (mostly women, children, and families), who have been – and continue to be – disenfranchised, neglected, and further harmed by the profession. The model strives to recognize, understand, and use information about structural discrimination and legacies of oppression that continue to impact the lives and psychological well-being of girls and women.

Treatment-induced trauma refers to specific wounds or harmful experiences that occur from treatment, which many partners experience. This can result from treatment that views the spouse/partner as a co-sex addict or codependent without recognizing that the person is a victim of abuse and experiencing traumatic symptoms. Treatment-induced trauma may also result from general therapy that is not aware of an abuse-trauma aspect, from couples' work where there is an assumption that the relationship is the problem since it "takes two to tango," or from sex therapy that encourages sexuality and intimacy with little work to address the abuse and trauma first.

Have you, your partner, or relationship(s) experienced any treatment-related harm?

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Exit Here:

Please leave with humility, remembering that no single one of us can heal abuse and trauma. We can only strive to provide a safe environment that will facilitate the human being's own organic capacity toward health.

Be gentle with yourself as you leave this DST healing space.

Glossary of Terms

Abuse-Victim-Trauma-Existing Reality	AVT-ER
Approach, Transition, Conditions	ATC
Assessed Vulnerabilities	AV
Assessment, Diagnosis, and Treatment Plan	ADT
Clinical (Conscious) Dignifying Circle	CDC
Cognitive-Behavioral Therapy	CBT
Communicate Authentically	CA
Complex Post-traumatic Stress Disorder	C-PTSD
Complex Trauma Shaping	CTS
Compulsive-entitled Sexuality	CES
Deny, Attack, and Reverse Victim and Offender	DARVO
Deceptive Compartmentalization	DC
Deceptive, Compartmentalized Sexual-relational Reality	DCSR
Deceptive Sexuality	DS
Deceptive Sexuality Trauma	DST
Deceptive Sexuality Trauma Treatment	DSTT
Integrity Abuse	IA
Integrity-abuse Disorder	IAD
Integrity-Safety-Humility	ISH
Intentional Clinical Frequencies	ICF
Intentional Vibrational Theory	IVT
Intentionally Accurate-Authentic Reality	IAR
Intentionally Manipulated Reality	IMR
Pre-existing Reality-ego	PRE
Post-traumatic Stress Disorder	PTSD
Rape Trauma Syndrome	RTS
Reality-ego Fragmentation	REF
Responsible Response(s) and Coping	RRC

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