

Developmental milestones in sexuality:
stepping stones to sexual health.

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ABSTRACT This presentation will explore the interface between an individual's sexual health, developmental milestones in sexuality and the human need for closeness. The latest scientific literature in the field of psychosexual therapy related to the topic will be reviewed. The potential contribution of the work of sex therapists to sexual health is clarified. Those who hold primary responsibility for sexual health are identified.

Responsibilities for Sexual Health

Parents are often very reluctant to think about a young child's sexuality- we all like to think of children as innocent and associate sex with loss of innocence. And appropriately so: sex is a physical activity that should not be part of children's lives whereas sexuality is a basic part of who we are. It involves feelings, values and relationships as well as intimacy and love. The development of sexuality is a lifelong process starting at birth, which is when parental responsibility for sexual health begins.

While I've got no interest in blaming as that's so unproductive, I do intend to identify clearly today the key ways in which parents are I believe those who hold the primary responsibilities for the sexual health of their children. There is now sufficient scientific information on the physiology of love to show how and why this is undeniably so.

Why am I telling you this? A group of venereologists??? There is a Plunket national conference on in Palmerston North just now so you'd be forgiven for considering the possibility that I've mixed up my papers. But in fact we have a couple of recent examples in New Zealand of surgeons and physicians lobbying government funding sources to achieve significant improvements in road safety. I hope you can see within the next half an hour there is a powerful equivalent embedded within this issue.

I will also argue that secondary responsibility for sexual health needs to be shared somewhat by your professions and mine. This collaboration has not happened well in New Zealand to date, if at all. I don't know why that is, but I hope to make clear the potential gains if we can do that in future.

The Concept of Sexual Health

Venereology is not my area of expertise and it is yours: so please forgive me if gaps in my knowledge are obvious. What I do know a great deal about though is healthy sexual behaviour. However I quickly realised from my brief foray into your sexual health literature that actually there are some very different perspectives from which we can think about this concept. Sex therapists define sexual health as those behaviours that are life enhancing, and not destructive to self or other.

Aggleton and Campbell (2000) have formulated what they call an affirmative concept of sexual health. It's made up of four preconditions:

- 1/ Absence of STI's and unwanted pregnancies.
- 2/ Reproductive health.
- 3/ All the rights and responsibilities that go with the expression of individual and collective needs (ie the need to respect variety and uniqueness of sexual experiences while at the same time affirming the right of all people to be free from sexual exploitation and abuse.)
- 4/ Attainment and expression of sexual pleasure (not repression or denial of sexual energies and desires).

Given that in my understanding, outside of Auckland, few regions in NZ provide psychotherapists to work within Sexual Health Clinics, I'm guessing that much of the work of those in this audience would revolve around efforts to help your patients achieve the first two conditions whereas much of the work of sex therapists revolves around the second two.

I believe all four pre-conditions are important to achieve sexual health and wellbeing and perhaps most importantly: as I see it, each is reliant on the others. That suggests that your professional group and mine need to be working far more with each other. I don't have statistics but I fear that the number of people who fail to achieve sexual health is alarmingly high. Perhaps we can take some responsibility for that with our failure to work co-operatively?

As a psychotherapist and sex therapist I would suggest there is an even more basic pre-condition underlying these four that forms the foundation of much of the work I and my colleagues do. I'm going to present to you some of the rationale for my belief in the connection between this core pre-condition and sexual health. But first let's look at the shared current understandings on the reasons why people take part in unsafe sex and fail to achieve sexual health for themselves.

The literature identifies many different contributing factors:

Adolescent factors

- way to show parents need for independence
- outlet for teenage frustration
- peer pressure
- young women seeing things thru men's eyes and not their own

to achieve the goal of losing virginity
to impress friends
to feel grown up
to avoid being called a name
to look hard and experienced
because its fun
lack of family support

Factors related to all ages

Expectations related to milieu (eg first year at university, first year in new city)
moral development
feelings of isolation
difficulties forming and maintaining relationships
media images about sex as glamorous and desirable
physical attraction
poor parental communication
lack of parental confidence and parenting skills
the appeal of danger and risk
lack of self worth and self esteem
vulnerability
lack of decision making skills
Lack of negotiation skills

Social factors

societal condoning of promiscuity
broader social and cultural context
pressures to conform to culturally defined ideologies of masculinity and femininity
insufficient/inadequate health education programmes
power relationships
social inequalities

It's clear that sexual behaviour, like all human behaviour is complex- there is no one theory that will completely account for it. As sexuality is itself imbued with guilt, fear, misunderstandings, pressures and feelings of inadequacy; sexual behaviours can contain even more layers of meaning than other behaviours that can put our health at risk such as poor driving or smoking. However I don't believe it is oversimplification to suggest to you that there are some core issues underlying these lists that if well addressed could make an enormous difference. They're pointed to in the factors listed but interestingly, not named.

Ideas on sexual health presented during last year's European Federation of Sexologists conference confirmed that a holistic model of sexual health is necessary to developing effective interventions. During the conference I learned from sexual health professionals working within primary care settings in various countries that despite this recognition there are barriers to using a holistic model. The two main ones were limited time resources and the fear of opening a 'can of worms'.

The Role of Sex Therapists

I propose that when different sectors can work together there are fewer barriers. Sex therapists with their background training in psychology and/or psychotherapy complimented by specialist training in the treatment of all issues of sexuality are quite at home with cans of worms. We see sexual behaviour as a window into individual and interpersonal functioning and believe that changing sexual behaviour requires changes that only occur in relationship- whether that is a professional or a personal one. As I aim to show, that is because the original patterns for self and other-destructive behaviour are formed in the most primary of all relationships: that between parent and child.

Some of you will be working from a quite different perspective. There will, I presume, be people in this audience whose primary responsibility is to provide sexual health education. No doubt a great deal of effort goes into making that education as effective as possible.

Wight (2002 SRT 17/4) found that a specially designed, teacher delivered, sex education programme in the UK was effective in improving knowledge about sexual health and reducing regret among teenagers but had no effect on use of condoms or other contraceptives. This author's conclusion was that the lack of effect on behaviour suggested that the education programme was unable to override broader social influences. I'm shortly going to outline for you an alternative explanation.

DiCenso et al (2002) evaluated primary prevention strategies and found they did not delay the initiation of sexual intercourse, improve use of birth control among young men or women or reduce the number of pregnancies in young women. These authors suggest wider recognition of environmental factors and social policy may be necessary to bring about marked change. Again, I would see another potential explanation.

It may also be the case that primary prevention strategies have changed direction in the past couple of years. I think what I'm about to suggest though may be a bigger move than has been considered to date.

Destructive Sexual Behaviour

I suggest that much unhealthy sexual behaviour occurs because people lack essential aspects of the capacity to achieve healthy sexual behaviour. Their destructive behaviour is the best way they know to try to meet their needs.

Why do people have sex? Aside from pure physical pleasure, which may or may not be achieved, I believe we have sex in pursuit of one of our most fundamental human needs: the need to feel loved and lovable. For every individual I've worked with who is or has been involved in casual sex with multiple sexual partners (surely the most at risk group for sexual health concerns) the core issue has been precisely that longing. Buried at various depths beneath "I felt horny" or "It's just what my friends do" or

“It’s what’s expected” is the expression of this need to feel loved in different ways “I want to feel wanted, desirable.” “I want to feel needed” “I want touch” “I was so lonely” “I want to be accepted.” All of those are expressions of the same basic need, being sought in destructive ways.

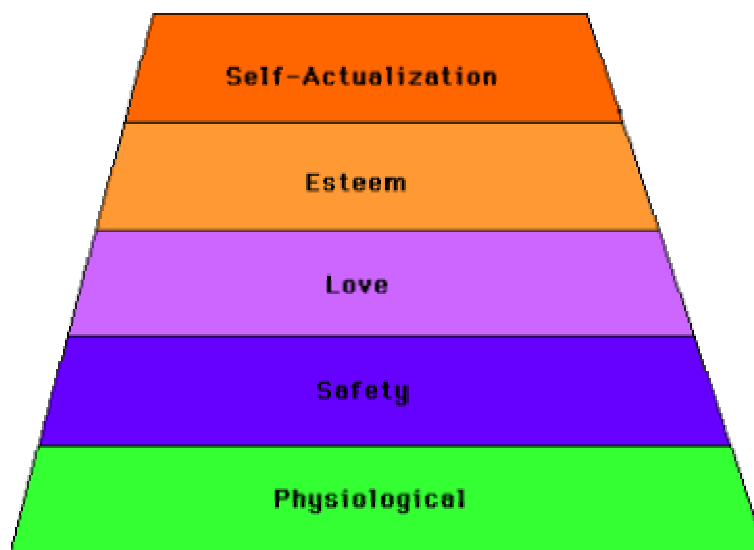
Irish author Colum McCann expresses it so well in his short story “Sisters” from his book Fishing the Sloe Black River.

“I remember when I was 15, cycling across those bogs in the early evenings, on my way to the dancehall in my clean, yellow socks. My sister stayed at home. I tried to avoid puddles but there would always be a splash or two on the back of my dress. Boys at the dancehall wore blue anoraks and watched me when I danced. Outside they leaned against my bike and smoked shared cigarettes in the night. I gave myself. One of them, once, left an Easter lily in the basket. Later it was men in granite-grey suits who would lean into me, heads cocked sideways like hawks, eyes closed. Sometimes I would hold my hands out beyond their shoulders and pretend that I could shape or carve something out of my hand, something that had eyes, and a face, someone very little, within my hand, whose job it was to try to understand.”

A couple of pages later we learn that this girl’s father is “... still caught in the oblivion caused, many years before, by the death of “ her mother.

The Centrality of Love

Maslow's Hierarchy of Needs



You'll be familiar I'm sure with Maslow's hierarchy of human needs. His model suggests that there are layers of needs with each layer being a pre-requisite to the next. He places sex alongside such basic physiological needs as air, water, food and sleep and puts love further up the pyramid. Yet studies in past decades of children raised in orphanages where they have received food, water, shelter etc (hopefully NOT sex) but missed out on loving care showed a marked failure to thrive- physically, intellectually, emotionally so we learned from those findings that there are ways in which love needs are also basic.

Sadly, getting our need for love met to an adequate degree is far more difficult than is often recognised. Neither scientific study nor social policy has very often been focused on this crucial human need. It is only in very recent years that love's physiology has been identified, allowing us to understand the fundamental importance of love, the mechanisms by which it is delivered and received and the obstacles to this happening well enough.

We've known for several decades now of the dangers to infant wellbeing of separation from the primary caregiver. The physiology of protest (Lewis et al, 2001) shows us that relationship rupture creates a severe bodily strain.

The Physiology of Protest

Behaviour:

- Increased motor activity.
- Increased vocalisation.
- Searching demeanour.

Physiology

- Increased heart rate.
- Increased body temperature.
- Increased catecholamine synthesis.
- Increased cortisol synthesis.

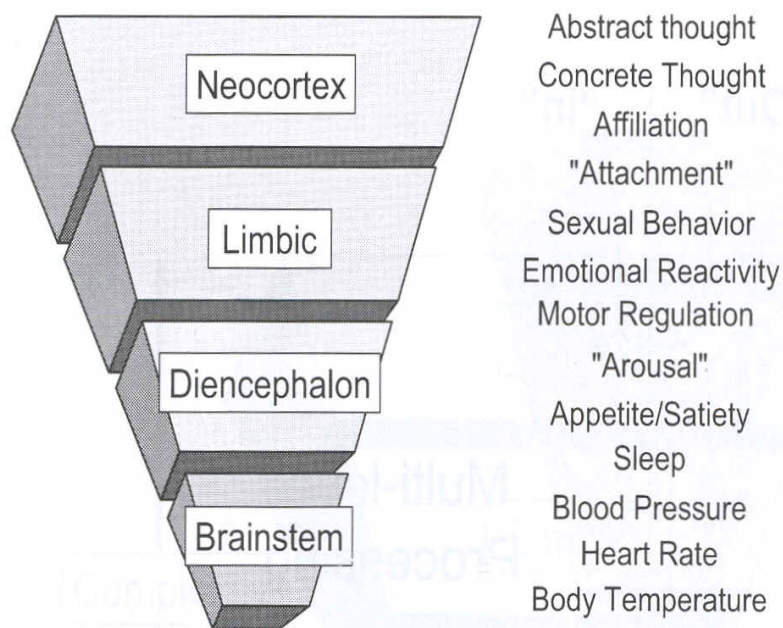
As an aside, it also explains something that some of you here may personally relate to: why losing a partner- through death or rejection, can be so terribly distressing. Separation from a loved one leads to an elevation in cortisol, the body's major stress hormone, which may well make it impossible to sleep. Abandoned adults also experience an inescapable inner restlessness, mistaken glimpses of the lost person, an urge to try to make contact etc. Babies and children not receiving sufficient attunement and responsiveness from their primary caregiver also go through this. If it is ongoing or too frequently recurring the physiological impact can be lifelong and very destructive.

So we have an understanding of the need for love but I don't believe it is yet well enough understood exactly what the mechanisms of effective love delivery are. I want to now outline those and show their relevance to sexual health. I need you to hold

onto this understanding that any serious disruption or inadequacy in the delivery of love will bring about important physiological consequences for the developing infant that we now know can be lifelong.

The Mechanisms of Effective Love Delivery

Most new parents have some understanding of the need to bond with their baby; they may not have the capacity to achieve such a bond. Nor may they know that this bonding is itself the process of forming an attachment- an enduring form of emotional relationship with a specific person that is essential for emotional wellbeing. The nature of attachment achieved influences a child for the rest of its life. It's not enough on its own but as the brain develops sequentially (see diagram) this is a crucial building block. Our need for love and the human interactions by which this is expressed has been proven to be essential for brain development by American neuro-psychiatrist Dr Bruce Perry.



I've already named the physiological input on brainstem regulated functions of any serious breach in the parent/infant relationship and you can see from this chart how that can then impact on higher brain function development. I won't go into the science of that but would encourage you to read Bruce Perry's work if you want to further your understanding on how this occurs.

We need now to focus on why it impacts so powerfully on sexual and other health. Parental neglect at crucial early times can actually do just as much damage as abuse and trauma. The scary fact is though that many of us who are parents do neglect some

of our children's essential needs NOT because we're evil or lazy or uncaring but because we didn't know they existed or because we haven't had these needs met in ourselves. Something needs to happen to break this cycle.

A newborn baby has no sense of self: it's only by the hand beneath its bottom and the other hand behind its head that a baby begins to develop an awareness of its body. The look in the parent's eyes, the tone of voice and the nature of the touch will transmit further crucial messages. Collectively the early years of messages received through all the senses will form the self concept; particularly powerful, lasting beliefs for the individual about whether he or she is loveable or not. These interactions will go as far as influencing the formation of neural pathways and powerfully shape later adult relating. (Lewis et al, 2001)

It's actually not sufficient to be a warm, loving, even doting parent. That certainly helps: A Finnish study (Ojantlatva et al., 2003) found in a study of 21,000 adults aged 20-54 identified that a warm, open and loving relationship with mother and/or father contributed positively to ability to form intimate relationship and sexual satisfaction in adulthood. Although those attributes are an excellent start we now know that what our children need as well is skillful attunement and appropriate responsiveness.

Research has shown that when babies look at faces, they're focusing on expressions on those faces. Infants just a few days old can distinguish between emotional expressions. Babies continually monitor expressions in the mother's face and their state of distress versus calm is regulated by that but if they're shown a video of their mother changing expressions the baby soon gets upset. It isn't just a need to see her smile, it's a need for the synchrony achieved by "mutually responsive interaction". (Lewis et al) Our mammalian cousin the dog will happily engage with a tug of war over a slipper but if you let go, they will too. It's not the slipper they want, it's the engagement with you, the interactive response.

The beginnings of our understanding this came from British psychoanalyst John Bowlby. He began to formulate his theory explaining the attachment process in the 1950's. At the time his work was responded to with derision by his colleagues however it has since been proven through research to have contributed greatly to our understanding of personality development, infant wellbeing and adult wellbeing. Bowlby thought the goal of attachment was to achieve physical security for the infant. In fact recent studies into the physiology of relatedness now tell us that attachment goes far further than that: it penetrates to the neural core of what it means to be human. (Lewis et al)

Healthy Intimate Behaviour

Without a secure attachment, children will struggle to develop social and interpersonal skills. These skills, which I'll describe shortly, are the pre-requisites for healthy intimate behaviour. No amount of sex education or persuading influences will allow an individual to achieve sexual health if they lack the capacity for intimacy. The

arousal generated sexual drive or the longing for love or both can easily override the intention to use a condom, if it was even there in the first place. The relational hunger that arises from attachment deficits leads to destructive efforts to fill a hole.

Telling insecurely attached people of any age they need to wear condoms or limit the number of their sexual partners is like telling a starving person they should only eat a little each day. If an individual has not experienced secure attachment they are likely to lack both the ability to self soothe through their loneliness AND the capacity to engage in healthy sexual relating that will meet their inner need. If they've experienced any trauma during their developmental years (neglect, physical violence, sexual abuse) they're likely to have a further problems. They may also lack the executive functioning capacity to make wise decisions. (Creedin, 2004) To understand why this is we need to delve a little further into the physiology of human beings.

The Physiology of Relating

Many people assume the body is self regulating. In fact some of our somatic symptoms are closed self-regulating loops, others are not. Eg it's well known that women who spend a lot of time together frequently find their menstrual cycles come into spontaneous alignment. Close friends achieve this more than roommates.

A baby by necessity out-sources most of its physiologic governance and gradually brings the duties back in-house over the early months-years. (Lewis et al, 2001) It learns to do this only through having that governance managed well on its behalf. Without that, a child will live with a level of chronic anxiety and other emotional disabilities. We've seen some of the physiology of that in looking at what happens during separation.

Even with skillful parental attunement and responsiveness it is now clear that we human beings never become fully self tuning: we are social animals who require others for our wellbeing. "Stability requires finding others who regulate you well and staying near them." (Lewis, p86)

There are some suggestions now that mammalian nervous systems depend on interactive co-ordination-ie steadiness comes from nearby attachment figure(s). (Lewis) This is limbic regulation- it fine tunes heart rate, blood pressure etc- many physiologic parameters. If we had a closed loop system we could spontaneously return to harmonious balance by ourselves. The chances of developing the capacity for closed loop systems decreases according to the quality of the attachment achieved.

When a primary caregiver is inconsistent in his/her attunement, the child will be unable to absorb sufficient closed loop control over their physiology so they will need to stay near an external regulator to remain in balance. Sadly but almost inevitably, their infant love experiences that shaped their beliefs about how loveable they are, will draw them to others who repeat those inadequate interpersonal experiences. Hence the repeating patterns that we so often see of, for example, a child of an

alcoholic forming an adult relationship with an alcoholic.

Developing a process for engaging the attention and responsiveness of a caregiver is an essential factor in childhood survival. That process (the fundamental dynamic of attachment) then defines the experience-dependent environment in which neural stimulation and growth will occur. (Creedin, 2004) No single neurotransmitter determines a response but 3 crucial chemicals appear important in limbic interactions: serotonin, opiates, oxytocin.

Between them Creedin (2004) and Perry (2001) explain how the neuro-developmental impact of trauma and insecure attachment results in problematic sexual behaviours. Basically the deprivation of neglectful developmental experiences or in the case of trauma; abnormal patterns of neurochemical cues due to extremes of experiences, can lead to disrupted neuronal organisation and diminished functional capacities.

That results in higher levels of arousal (physiological arousal, but this is often sexualized), more impulsivity, aggression, poor decision making skills. I imagine these characteristics will be familiar to you from your client group. Lower and mid brain responses have organized around experiencing persistent, low level states of fear and anxiety.

The effects of that on hormone production can then impact on sexual behaviour. Teicher et al., (2002) have explained how altered levels of vasopressin and oxytocin resulting from early neglect or abuse can predispose people to suffer from enhanced sexual arousal, diminished capacity at sexual fulfillment and insufficient commitment to maintain a single partner.

Essential Skills for Healthy Sexual Behaviour

Some of the essential skills for responsible sex are arousal and impulse control, attunement, empathy, a recognition of the impact and consequences of one's behaviour. These require appropriately integrated levels of cortical control. I have shown how developmentally and physiologically this is achieved through sufficient parental attunement and responsiveness. Without those basic needs being met sex education is unlikely to be helpful for anyone who has experienced neglect or trauma during their early developmental stages.

To some extent it is normal adolescent behaviour to have poor decision making skills, quickly shifting moods, and to seek highly charged emotional experiences. However a blanket acceptance of this can cloud our recognising that some of those deficits are actually a consequence of developmental deficits and will not be "grown out of" without an ongoing experience in a sound relationship: professional or personal.

Larson (2000) showed that family of origin experiences set the stage for healthy or unhealthy interpersonal relationships outside of the family by providing a powerful blueprint for interaction. The studies I have described show why and how this happens.

For Your Ongoing Reflection:

- 1/ There is an urgent need for a focus on parenting so that all new parents are helped to obtain the skills of attunement and responsiveness. There are now organisations such as Brainwave and Plunket's PAFTs educators addressing these issues on a small scale but far more needs to happen. Groups of stakeholders such as yourselves need to be lobbying government for prioritising such enormously important preventative services. Its SO much more effective to get it right from the beginning: both cost effective and productive. These life skills are the safety barriers down the middle of dangerous roads.
- 2/ There is a need for collaboration in the sexual health field. Sex therapists can offer an essential service to your client group.

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