# SEXUAL ADDICTION AND COMPULSION: RECOGNITION, TREATMENT & RECOVERY

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CNS Spectrums 2000; 5(10): 63-72

## *ABSTRACT*

*The management of patients with compulsive sexual behavior requires an understanding of the profile of the sexually compulsive or addicted patient. This article summarizes patient characteristics and their implications for treatment. Data from a study of the recovery of 957 patients who had problematic, sexually excessive behavior are presented. Spanning 5 years, the study shows six distinct stages patients experience and the clinical activities that were most useful to them. A trajectory of a typical diagnosis and treatment path is provided, as well as important resources for physicians and patients.*

*CNS Spectrums 2000; 5(10): 63-72*

## *INTRODUCTION*

With greater awareness of sexual exploitation, sexual misconduct in the workplace and public attention regarding sexual disorders, more cases of sexual compulsivity will be brought to the attention of physicians. Thus, physicians ought to have an understanding of addictive/compulsive problematic sex in order to make appropriate management decisions and to evaluate clinical approaches. The purpose of the article is to review the nature of the problem, the typical course of treatment and recovery, and critical factors for monitoring a patient's progress.

During the last three decades, professionals have acknowledged that some people have uncontrolled sexual behavior. People with sexual compulsivity are similar to compulsive gamblers, compulsive overeaters, or alcoholics in that they are not able to contain their impulses, which lead to destructive results. For this reason, they are often referred to as sexual addicts. Depending on one's professional framework. The words addiction or compulsions have been used to describe the disorder.[1] In the field of addiction medicine, one of the signs of addiction is compulsive use. Some professionals may make distinctions between addiction and compulsion; others may use them interchangeably. There is, however, a growing common understanding of the problem and how it occurs. Great progress is also being made in treatment. Advances in neurochemistry may soon redefine our terminology as we understand more clearly the biology of the disorder.[2]

## *PROBLEM RECOGNITION*

The first issue for clinicians is recognition of the problem. Typically, persons with problematic sexual compulsivity are not candid about their behavior, nor are they likely to reveal that the specific behavior is actually part of consistent self-destructive pattern. The nature of this illness causes patients to hide the severity of the problem from others to delude themselves about their ability to control their behavior and to minimize their impact on others.[3] This includes being deceptive with their physician because of their immense shame. If they hold any type of leadership position (e.g., church, business, community, or political), the fact that they are to be

models of moral behavior compounds the problem because their position adds to their shame and fear.

Often, some event may precipitate a visit to the physician. The incident will be presented as a onetime event or simply as a moral lapse, and may lead to marital therapy. However, if a sexual compulsion is present the problem will not disappear without more specific therapy. A wide range of behaviors can be problematic, including compulsive masturbation, extramarital affairs, pornography use, and use of prostitutes, voyeurism, exhibitionism, sexual harassment and criminal sexual misconduct. Patients with problematic sexual compulsivity seldom have just problem behavior, but rather show a variety of problem behaviors that often cluster together.[4] [5][6] For example, in addition to multiple extramarital affairs, there might also be use of prostitutes, pornography, and cybersex as well as masturbation. The following situations should prompt the clinician to assess a patient for the presence of sexual compulsivity:

- The patient volunteers that there is a long-term pattern of problematic sexual behavior. There are occasions when the person will give in to despair and let others know about the extent of his or her troubles.

- The clinician has evidence that there is a pattern of behavior. For example, if the clinician knows there is a pattern of extramarital affairs and hears reports from the spouse that there is evidence that the patient uses a massage parlor or prostitute, a pattern starts to emerge. A history of sexual issues over time also indicates a problem.

- There is a sexual incident and the clinician knows that other excessive, uncontrolled behaviors also exist, such as alcoholism, compulsive eating, compulsive working, or compulsive gambling (or a history of these behaviors exists), in addition to evidence of a sexual problem. Most often, compulsive behaviors occur together and amplify each other.[7] [8]

- The behavior involves the abuse of power, including sex with children, congregants, employees, patients, or other persons under the authority of the affected person. Any exploitation of power or complaint of exploitation should immediately trigger an assessment and temporary removal from duties. (Evidence of child abuse or dependent adult abuse may be required to be reported in many jurisdictions.)

- There are unexplained problems coupled with a sexual behavior. Unexplained absences, failure to perform expected tasks, and the disappearance of large sums of money could all be part of a compulsive pattern (e.g., compulsive affairs or sue of prostitutes could be the issue).

The discovery of an inappropriate sexual incident does not always indicate an addictive illness. A long-term extramarital affair, for example, may be a problem for a spouse, but does not represent a compulsive pattern. Likewise, exploitive or even violent behavior does not indicate a sexually addictive illness. For example, in a recent study of sex offenders, only 72% of pedophiles and 38% of rapists fit the criteria for sexual compulsivity.[9]

Finally, it is important to note that women can have the problem too. In fact, for every three men with sexual compulsivity, there is one woman with the disorder.[10] [11]This ratio parallels the gender ratios of compulsive gambling and alcoholism. The expectation of many that women (especially moral or religious women) do not have this problem helps keep it secret. A female patient suffers the shame of having a sexual disorder and also from being a woman who has lost control.

The following examples illustrate the diversity and complexity of sexual compulsion:

- A parish pastor had a $1,000/weekprostitution habit, after depleting his family inheritance, he started to use parish funds by removing loose cash in the parish collections and making out false payroll checks for staffing who did not exist. He fancied himself as having a ministry to the prostitutes he used. He also did not see himself as violating his vow of celibacy, since he was an emotional virgin with no relationship commitments.

- A 37-year-old social worker had been married for 13 years. Yet even on the day she married, she was having an affair. Her unusual pattern was to have two or three affairs at a time. She was confronted by her therapist about her compulsive affairs, but she dismissed the therapist saying that the problem was her marriage. She then discovered the Internet and chat rooms. While her husband slept, she repeatedly engaged in romantic, sexual talk with many men simultaneously throughout the night. Romanic intrigue escalated to phone sex: phone sex led to her meeting with men in hotels. She finally was beaten and left for dead in a hotel room by a man she met through the Internet.

- A 71-year-old chief executive officer of a very successful office products manufacturing company received two sexual harassment complaints in a matter of a few weeks. The company hired an investigator to do a company audit of sexual harassment. More than 70 women (past and current employees) came forward with stories of constant propositions, fondling, and affairs. The investigation further revealed similar stories among vendors. Trades people, family friends, and very unfortunate incident with his daughter-in-law.

- A 40-year-old married gynecologist had a pattern of initiation relationships with his patients after he conducted examinations of them. He also had a history of relationships with nurses both at the hospital and in his own staff. His current affair with his own staff member involved extensive financial support of a person who was clearly not competent to do assigned work. What precipitated the crisis that brought him to treatment, however, was a hospital audit of computer usage, which revealed this physician was extensively downloading pornography, particularly of young and adolescent women.

- A 35-year-old chemical dependency counselor had a severe problem with pornography and strip bars. He also masturbated six to eight times a day, sometimes in unsafe situations such as in his car. He was married to a woman to whom he was attracted and whom he said he deeply loved; however, he was sexually avoidant with her.

- A successful businessman had problems with both sexual compulsivity and substance abuse. When he drank, he liked to arrange threesomes with prostitutes and was very directive as to what they should do. When he used cocaine, he was very passive and would masturbate for up to 15 hours without stopping. Sometimes on his cocaine/masturbation binges, he would also cross-dress and hire a prostitute to assist with the masturbation.

The common theme in these examples is sexually compulsive behavior. These individuals have reached a level of sexual frequency and loss of control that is self-destructive. Like compulsive gamblers, compulsive overeaters, or alcoholics, they will make repeated efforts to stop but are unsuccessful. They know that to continue will bring disaster; yet, they continue the behavior.

Table 1 lists criteria some clinicians use to diagnose this condition. The second column shows how patients rated themselves initially, and the third column shows how they viewed themselves after long-term treatment, averaging 2½ years.[12]

**Table 1. Diagnostic Criteria and Patients in Initial and Long-Term Treatment Who Fit These Criteria**

| CRITERIA | TREATMENT INITIAL (N=437) | DURATION LONG-TERM (N=57) |
|---|---|---|
| Recurrent failure (pattern) to resist sexual impulses to engage in specific sexual behavior | 73% | 94% |
| Frequent engaging in those behaviors to a greater extent or over a longer period of time than intended | 66% | 93% |
| Persistent desire or unsuccessful efforts to stop, reduce, or control those behavior | 67% | 88% |
| Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experiences | 58% | 94% |
| Preoccupation with the behavior or preparatory activities | 37% | 77% |
| Frequent engaging in the behavior when expected to fulfill occupational, academic. domestic, or social obligations | 52% | 87% |
| Continuation of the behavior, despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior | 63% | 85% |
| Need to increase the intensity, frequency, number, or risk of behaviors to achieve the desired effect, or diminished effect with continued behaviors at the same level of intensity, frequency, number, or risk | 36% | 74% |
| Giving up or limiting social, occupational, or recreational activities because of the behavior | 51% | 87% |
| Distress, anxiety, restlessness, or irritability if unable to engage in the behavior | 55% | 98% |

*Carnes, P.J., CNS Spectrums, Vol. 5., No. 10. 2000.*

## *PROFILES OF COMPULSIVE BEHAVIOR*

A review of the characteristics of those affected by compulsive sexual behavior will help clinicians understand the requirements of treatment. These traits are mainly from a study of nearly 1,000 sex addicts.[13] Critical characteristics include the following:

- *Distrust of authority.* Most patients are from dysfunctional families who have a significant problem with addictive and compulsive disorders. Only 13% of the families of origin have no addictions or compulsive disorders reported. Children who grow up in dysfunctional families are extremely rigid and controlling. Children from these families tend not to develop normal abilities of self-limitation and responsibility, To comply with authority means an essential loss of self. As adults, they are comfortable hiding things from those in authority and are resistant to accountability.

- *Intimacy deficit*. More than 87% of these patients come from disengaged family environment in which family members are detached, uninvolved, or emotionally absent. Compulsive sexual behavior is a sign of a significant intimacy disorder and the inability to meet emotional needs.

- *Post-traumatic stress disorder*. Sexually compulsive patient often have a history of sexual abuse, physical abuse, and emotional abuse. Addictions become a way to manage their stress disorder and may include repeating the trauma compulsively.

- *Extreme eroticization.* One of the effects of abusive families and childhood sexual abuse is that, as adults, survivors sexualize all interactions. They often sense that other people do not have the same relationship filters they do, which adds to their sense of shame.

- *Shame-based sense of self*. Shame stems from a failure to achieve a positive sense of self and profound belief in one's lack of worth. The constant failure to stop the behavior you hate confirms your belief that you are fundamentally flawed and unlovable.

- *Compartmentalization.* A survival mechanism for abused children is to compartmentalize in order to avoid reality. For adults this means dividing up life into compartments. This explains both a person who believes that no none will discover their sexual behavior as well as a person who can lie to others without distress.[14]

- *Compulsive cycles.* Most addicts (72%) binge and then feel despair-much like a person with bulimia will binge and purge. For example, a number of clergymen preach against promiscuity or some sexual behavior only to be discovered engaging in or arrested for that behavior. In their public pronouncements they were purging, while privately they were clearly binging. These cycles add to both shame and compartmentalizing.

- *Self-destructive behavior*. Many patients report high-risk behaviors, which result in severe consequences, such as loss of career or arrest. Children who are sexually abused often integrate fear into their arousal patterns. For sex to work for these adults, it has to have a fear component, which results in risk-seeking sex. Frequently, these patients reported knowing their behavior would be disastrous, but engaged in it anyways.

- *Other addictions or compulsions*. Seldom do these patients have only a sexual problem. For example. 41% have problems with alcohol or drugs, and 38% have an eating disorder. Other problems include compulsive gambling, compulsive spending, and nicotine addiction. Usually, compulsive sexual behavior is part of an intricate wave of behaviors to manage internal distress. For example, one study has shown a close connection between cocaine use and sexual acting out.[15] Various reports also document switching or replacing one set of addictive/compulsive behaviors with another set.[16 17]

- *Concomitant mental health disorders:* These patients often have a co morbid psychiatric disorder. As with all addictive and compulsive disorders, there often is acute depression that is constantly intensified by the failure to control sexual behavior. Other issues include other mood disorders, anxiety disorders, and abnormal personality traits, all of which complicate treatment planning.

The main treatment challenge is to provide a therapeutic environment that gains the trust of the patient, but also hold the patient accountable. Furthermore, sufficient containment must be instituted to stop self-destructive behavior. Once containment is established, the issues of family control, dysfunction, and abuse can be addressed. Tools for managing stress, shame reduction, and relapse prevention are essential. Providing information about normal sexual behavior and compulsive sexual behavior is critical. Cognitive behavior techniques should be used to disrupt cognitive distortions and dysfunctional beliefs. Other co morbid psychiatric disorders also must be addressed as part of the treatment plan.

## *THE RECOVERY PROCESS*

The author and colleagues initiated a study in the mid 1980s in an effort to understand recovery from sexual compulsion.[18] For the study, recovering sex addicts and their partners were asked to complete a number of instruments including an extensive life status inventory and a month-by-month history of their recovery. We also interviewed people with extended recovery in a stage-by-stage fashion and analyzed their responses. The following overview of a 5-year recovery process is bases on changes in quality-of-life variables. (See Table 2 for a summary of findings.)

| Table 2. Categories of Recovery Over Time | | |
|---|---|---|
| WORSE | BETTER | |
| SECOND 6 MONTHS | YEARS 2 & 3 | YEAR 3 PLUS |
| Relapse | Financial situations* | Healthy sexuality |
| Health status | Coping with stress* | Primary relationships |
| | Spirituality | Life satisfaction |
| | Self-image | Relationship with family of origin |
| | Career status* | Relationship with children |
| | Friendships* | |
| ** Continued to improve 3 years plus.* | | |
| *Carnes, P.J., CNS Spectrums, Vol. 5., No. 10. 2000.* | | |

## The First 5 Years of Recovery

***First year:*** There was no measurable improvement, and yet most sexual addicts reported that life was "definitely better." This apparent contradiction might be explained by one respondent's comment that "when you are hitting your head against the wall, even stopping the hitting helps." According to our assessment, some aspects of functioning actually became worse. Most slips tended to occur in the second 6-months to be the worst over the 5 years. The first year appeared to be characterized by turmoil, which tests the person's resolve to change. Some of the consequences of sexual addiction continued, and the change itself was difficult.

***Second and third years:*** Once through the first year, significant rebuilding began. There was measurable improvement occurring in many areas, including finances, ability to cope with stress, spirituality, self-image, career status, and friendships. These indicators reflected a period of intense personal work, which resulted in more productivity, stability, and a greater sense of well-being.

***Third, fourth, and fifth years:*** Once the personal base of recovery was established, healing occurred in the sexual addicts' relationships. Often, dramatic improvement occurred in their relationships with children, parents, siblings, and partners, with some exceptions. About 13% found that unresolved issues with their family of origin could not be healed because the family was abusive or was threatening to recovery. Also, some marriages were casualties to the recovery process. Most important, sex addicts reported shifts toward more healthy and satisfying sexual expression. With improved relationships, overall life satisfaction improved dramatically.

## Six Stages of Recovery

A series of content analyses were also conducted in the study, which enabled the discernment of six stages in which these quality-of-life changes occur. The stages are summarized as follows:

***Developing Stage (lasts up to 2 years):*** During this period, the sexual addict's problems mount and create an awareness that something needs to be done. The person may seek therapy or attend a 12-step group, then drop out. It was also noted that many therapists failed to see the problem of sexual acting out, or if they did see it, failed to follow through on it. Even knowledgeable therapists felt shame at this stage because the patient dropped out of therapy. They would tell themselves that if they had been better therapists, the patient might have persisted. Research showed that no matter what therapists try at this stage, patients still might not be ready. Persons with compulsive sexual behavior have a growing appreciation of the reality of the problem, but tend to minimize the problem or believe they can handle it themselves. Some persons temporarily curtail their behaviors or substitute other behaviors (e.g., switching from exhibitionism to use of prostitutes).

***Crisis/decision stage (1 day to 3 months):*** At some point, the addict crosses a line where there is a fundamental commitment to change. This is often precipitated by a personal crisis. This crisis may include all kinds of events, such as arrests, diagnosis of a sexually transmitted disease, a spouse (or partner) leaving, learning of a positive human immunodeficiency virus test, facing a sexual harassment lawsuit, loss of professional license, a car accident, involving death or injury, or a suicide attempt. For example, sometimes a crisis is precipitated by a therapist or employer who refuses to continue enabling destructive behaviors (e.g., an employer who will no longer run the risk of sexual harassment suits or pay for cybersex on a company computer). For some of our respondents, the commitment to change was not about crisis, but rather about choice. They simply were no longer willing to exist in the old way. They reflected the old aphorism from Alcoholics Anonymous of "being sick and tired of being sick and tired" and had become willing to go to any lengths to get better.

***Shock Stage (first 6 to 8 months):*** Once they admitted the problem, addicts enter a stage that parallels what happens to anyone who has experienced deep loss and change. Disbelief and numbness alternate with anger and feelings of separation. Addicts describe physical symptoms of withdrawal that are at times agonizing. They also report disorientation, confusion, numbness, and inability to focus or concentrate. Feelings of hopelessness and despair become more intense as their sense of reality grows. Sexual addicts become reactive to limits set by therapists, sponsors, or family members. When they join a recovery group, they experience a sense of belonging along with the realization that recovery was the right decision for them. The time-honored 12-step wisdom, distilled in slogans such as "Keep it simple" and "One day at a time" appears to be very appropriate at this point. They report feelings of relief and acceptance once the double life is over.

***Grief Stage (6 months):*** As they emerge further from their shock, patients become aware of the emotional pain. Their suffering has several components. First, there is awareness of all the losses caused by their sexual addiction, including jobs,

relationships, children, time, money and physical well-being. Second, there is a sense of loss as the sexual addiction causes to serve as friend, comforter, and emotional high. Third, the sexual addiction has masked deeper hurts usually stemming from early childhood abuse or neglect. Without the cover of the addictive process, memories return and clarity about those early wounds emerges. Understanding the level of suffering at this point helps to explain why the relapse rate was so high during this time period in our study.

***Repair Stage (18 to 36 months):*** Sexual addicts who were successful in negotiating the rigors of the previous stage move from the pain into a deep, internal restructuring. Belief systems about self, sex, family, and values are overhauled. New patterns of behavior develop. Systems theory would describe this stage as a "paradigm shift". It is a second-order change in which the programming or internal rules are different vs. first-order change, which is characterized by using the old solutions with greater energy (try harder). But, when the paradigm changed, the improvements were dramatic. It was noted that sexual addicts took responsibility for themselves in all areas of life, including career, finances, and health. They reported a new ability to express their needs and to work to meet them. A common thread in our study was the deepening of new bonds with others. Sexual addicts also reported efforts to complete projects (e.g. being on time, following through, responding to requests).

***Growth Stage (2 years plus):*** As sexually compulsive persons achieve more balance in their lives and develop a greater sense of themselves, they become more available to others. Relationships with partners, friends, children, and family go through a period of renewal. Here, too, is where life-satisfaction measures showed improvement in the study. Sexual addicts reported expressing more compassion for themselves and others. They developed a new trust for their own boundaries and integrity in relationships.

## *TREATMENT AND SUPPORT OPTIONS*

Participants in the study who achieved a significant amount of time in recovery (n=190) were presented with a list of treatment and support resources and asked to indicate whether they had used them and if they were helpful.[19] The participants were also asked to indicate anything else they had tried and whether or not that, too, was useful. Table 3 summarized the results of this portion of our survey. A number of factors stood out as being helpful in recovery, including the following:

- Inpatient treatment experience
- Group treatment experience
- Long-term individual therapy
- Participation in 12-step programs
- An active and knowledgeable sponsor
- An ongoing spiritual life
- The support of friends

- A period of celibacy
- Regular exercise and balanced nutrition

**Table 3. Treatment Choices of 190 Persons Asked to Note the Helpfulness of Various Treatment Options**

| TYPE OF TREATMENT | HELPFUL | NOT HELPFUL |
|---|---|---|
| Inpatient treatment | 35% | 2% |
| Outpatient group | 27% | 7% |
| Aftercare (hospital) | 9% | 5% |
| Individual therapy | 65% | 12% |
| Family therapy | 11% | 3% |
| Couples therapy | 21% | 11% |
| 12-Step Group (for SA) | 85% | 4% |
| 12-Step Group (other) | 55% | 8% |
| Sponsor | 61% | 6% |
| Partner support | 36% | 6% |
| Higher power | 87% | 3% |
| Friends' support | 69% | 4% |
| Celibacy period | 64% | 10% |
| Exercise/Nutrition | 58% | 4% |

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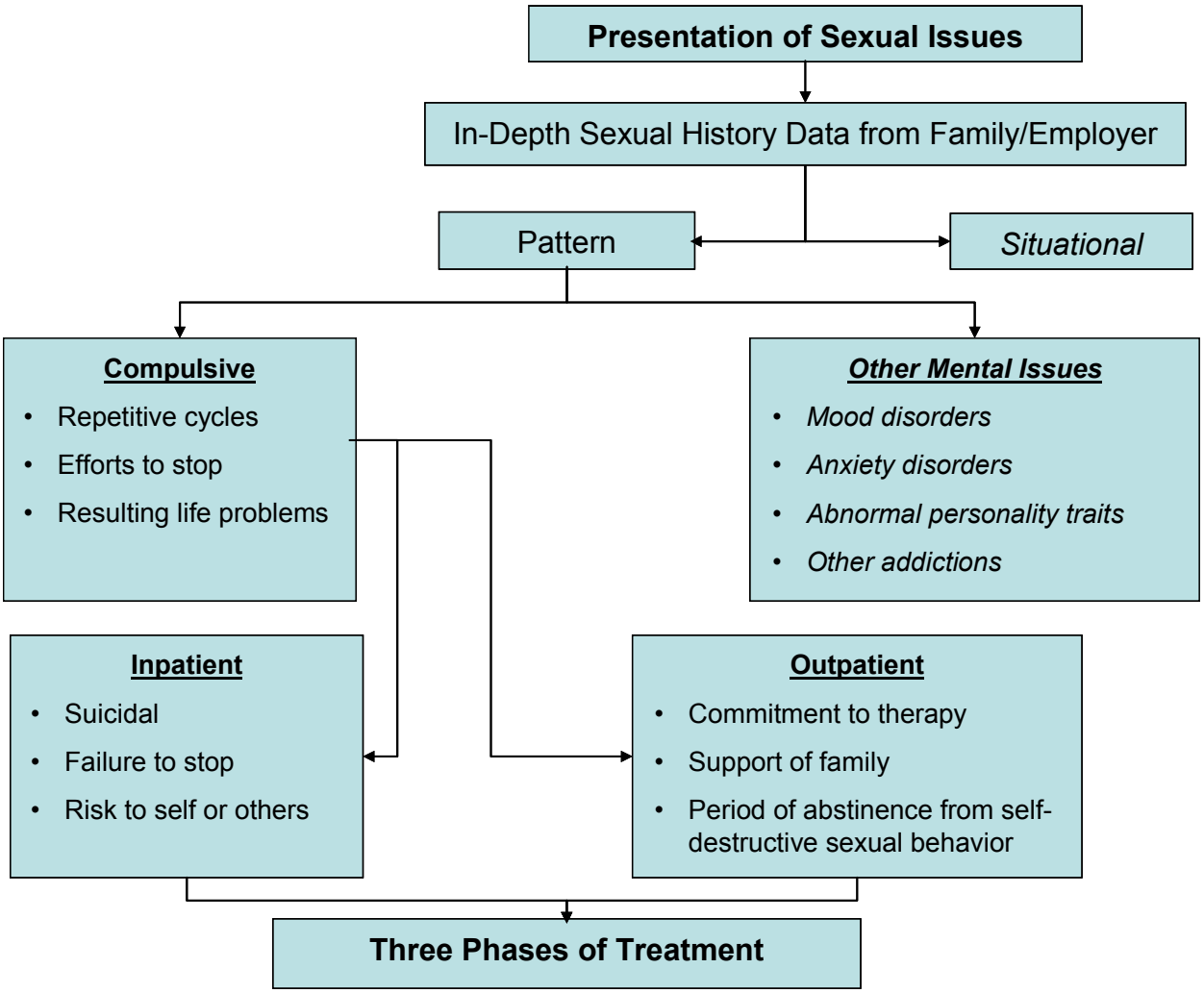
The results indicate that recovery is a long-term process. Brief interventions, including therapy, medication, or limited hospital stays, did not produce the desired results. Because compulsive sexual behavior often results from a combination of powerful family forces, neurochemical interactions, and early childhood trauma, there is no quick fix. In addition, it became clear that success was dependent on patient follow-through. If the patient did not follow the treatment plan, success was marginal. This changes our perceptions of measuring outcomes. For example, completing steps 1 though 3 of a 12-step program at an inpatient facility, but never actively completing further steps or attending further therapy, lessens the chance of success no matter how effective the program. Similarly, individual therapy without the support of the patient's partner or a 12-step fellowship significantly reduces desired outcomes.

## *DIAGNOSIS AND TREATMENT PATH*

The Figure on the following page provides a schematic overview of the diagnosis and treatment path involved in therapy with the sexually compulsive or addictive patient. When the patient presents sexual issues involving a loss of impulse control, the physician conducts an in-depth sexual history. If the situation has escalated to the point where the family, the employer, or the legal system is involved, all the data should be gathered. To rely on the patient alone around these

sensitive issues does not help because of characteristic denial. Interviewing family members or obtaining copies of lawsuits, legal charges, or company complaints is vital. Comparing what the clinician learns with the patient's version is often the beginning of therapy. The physician needs to confront the patient about discrepancies so a clear picture emerges.




The physician then must decide whether the sexually excessive behavior is situational or part of a pattern. If situational, then the focus is on the patient's response to the situation. If it is a pattern, there will be a repetitive set of recursive sexual events in which there is significant loss of control. This pattern may in fact be punctuated with periods of sexual aversion followed by binging. The physician then must make the decision that the behavior is about compulsivity and not other mental health issues. Sexual impulsivity may be found with bipolar or borderline conditions as well as with alcohol and drug abuse. Therefore, it is important to rule out other mental disorders that would explain the behavior. If the behavior fits the criteria for sexual addiction/compulsion, including the essential elements of repetition and the inability to control one's behavior despite causing significant life problems, a compulsive pattern exists.

The next decision is the level of intervention. Some patients are appropriate for inpatient settings, particularly if they are suicidal or are a significant risk to themselves or others. Failure at an outpatient level may also indicate the need for hospitalization. A patient who continues high-risk, life-threatening sexual practices despite all outpatient efforts is a candidate for inpatient treatment. Signs of a good prognosis on an outpatient basis are a significant commitment to therapy: an involved, intact supportive family; and significant periods of time in which the patient was able to abstain from self-destructive behavior.

## *THREE PHASES OF TREATMENT*

Treatment can be divided into three phases, whether it is outpatient or inpatient (Table 4). The first phase is about intervening in the cyclical compulsive process. The physician must extend the patient's sexual history to include all aspects of the problematic behavior. This survey is important, because it gives both the patient and physician an awareness of the extent of the problem. The physician's inquiry will help the patient understand the severity of the problem, and the physician most likely will be less surprised by unpleasant disclosure that occur later in therapy; however, sometimes surprises will happen regardless of what preventative measures are taken.

**Table 4. Three Phases of Treatment**

| PHASE I: INTERVENTION |
|---|
| • Survey extent of problematic behavior<br>• Teach about illness<br>• Referral to 12-Step Program<br>• Confront denial<br>• Agree on behavior contract |
| **PHASE II: INITIAL TREATMENT** |
| • 12-Step attendance<br>• Complete first step of 12-step process<br>• Agree on writing an abstinence definition<br>• Written relapse-prevention plan<br>• Complete period of celibacy<br>• Develop a sex plan<br>• Partner and family involvement<br>• Multiple addiction assessment<br>• Trauma assessment<br>• Group therapy<br>• Shame reduction |
| **PHASE III: EXTENDED THERAPY** |
| • Complete steps 2 – 4 of 12-step process<br>• Developmental issues<br>• Family-of-origin issues<br>• Grief resolution<br>• Marital and family therapy<br>• Career issues<br>• Trauma therapy |
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During the initial phase of treatment, therapy focuses on teaching the patient about the illness. In addition to coaching from the therapist, the patient must read and learn about the problem. The next section provides a list of resources where patients can obtain such information. The initial phase of treatment is also the time to refer the patient to a local 12-step group for sex addiction or sexual compulsion. As the patient starts to trust the therapist and becomes more familiar with the disorder, it is time to start confronting areas of significant denial in the patient. The best place to start is with the most obvious and the most dangerous. Behaviors that are clearly self-destructive such as exhibitionism in a shopping mall, unprotected sex with prostitutes, or sex with dangerous persons have to stop. At this point, the therapist develops a behavioral contract with the patient about behaviors the patient will abstain from while in therapy. For example, if exhibitionism in a shopping center is a problem or compulsive use of prostitutes occurs in a certain area of town, the patient agrees not only to refrain from these behaviors, but to avoid going to these areas alone. The patient also agrees to report any problems.

Once this foundation is in place, the second phase of treatment can begin. The following strategies are typically employed at this time (during the first 4 to 8 weeks of treatment) for either inpatient or outpatient treatment:

- ***12-Step Program Attendance***. Mandatory 12-step program attendance is required, and a temporary sponsor is found. Patients need the support of those who have faced the same issues.

- ***Completion of the First Step***. The 12-step program starts with a first step in which patients acknowledge problems that, on their own, they have been unable to stop. Inventories of efforts to stop and consequences of sexual behavior are used to break through denial. This step is presented both in the support group and in therapy.

- ***Written abstinence statement***. This is a carefully scrutinized list with three parts (1) the destructive behaviors the patient agrees to abstain from, (2) the boundaries needed to avoid those behaviors, and (3) a full statement of the sexual behaviors the patient wishes to cultivate. All of these are carefully reviewed in therapy and in the support groups.

- ***Relapse prevention plan***. With the therapist's help, the patient prepares a comprehensive plan to prevent relapse, including understanding triggers (specific items/events that activate patient's rituals and addiction obsession) and preceding situations (e.g. extreme stress, a fight with spouse, etc.) that area not directly related to sex as well as performing "fire drills" (i.e. automatic responses to prevent relapse).

- ***Celibacy period***. The patient is asked to make a commitment to celibacy, which includes masturbation, for 8 to 12 weeks. If the person is part of a couple, their partner must also commit to this process. This period is designed to reduce the sexual chaos and to teach how sex has been used as a coping mechanism. It also creates a window to start to explore conceptually what constitutes sexual health. Often during this period, the patient will experience memories of early childhood sexual and physical abuse.

- ***Sex plan***. At the conclusion of the celibacy period, the therapist and patient create a sex plan, which further articulates the difference between destructive and healthy sexuality.

- ***Partner and family involvement***. Partners and family members go through therapy about the impact of the behavior. This is to further confront the denial, but also to help those close to the patient engage in therapy for themselves.

- ***Multiple addictions assessment***. Addictions and compulsions work together in various ways. The therapist helps the patient to see that addictions, compulsions, and deprivations are all part of the repetitive pattern. The relapse prevention plan and sex plan are adjusted accordingly.

- ***Trauma assessment***. A complete assessment of abuse and assault is done by the physician. This assessment helps clarify the goals of long-term therapy. For many patients whose behavior stems from early abuse, this becomes key to understanding their behavior as the acting out of scenarios and provides important psychological distance from the addictive pattern.

- ***Group therapy***. Patients participate in an ongoing group. Optimally, this would be a group who share the same issues, but follow-up studies have indicated that any ongoing group makes a substantial difference.

- ***Shame reduction***. The therapist works with the patient using various strategies to reduce both sexual shame and shame about past behavior.

Once a period of relapse-free behavior has taken place, the third phase of treatment may begin. This phase focuses on underlying developmental issues and family-of-origin issues as they are reflected in the patient's sexual acting out. If substantial abuse is part of the picture, therapy to de-escalate reactivity and defuse sexual triggers to inappropriate behavior is required. Furthermore, physicians will find substantial amounts of unresolved grief, which will require attention. As noted earlier, sometimes the grief leads to slips into old behavior. Unattended grief can precipitate total relapse. During this period, the patient must continue working the steps of the 12-step program. In an unpublished outcome study, the authors found that only 23% of patients actually completed steps one through nine of the 12 steps in 18 months. Among these patients, relapse was rare.

Many patients' careers have been adversely affected by their behavior. As previously noted, some may never return to the career for which they were trained. This becomes an issue that must also be dealt with therapeutically. Similarly, marriage partners and family members require extended therapy to overcome feelings of betrayal and loss as well as to understand the role of family dysfunction in the compulsive cycles.

Finally, if the behavior involved criminal sexual misconduct and was part of a compulsive pattern, treatment time is usually extended dramatically. In part, this is usually a developmental issue requiring other therapeutic components, which promote victim empathy and accountability.

## *READING AND RESOURCES*

In addition to works already cited, a number of key contributions exist on the treatment of this illness. In their book, *Sex Addiction: Case Studies and Management*, Earle et al have compiled a collection of case discussions that provide examples of intervention strategies. Goodman's book, *Sexual Addiction: An Integrated Approach*, discusses the dynamics of sexual addiction and is a valuable resource for case management. Of interest to physicians is *The Wounded Healer* by Irons and Schneider[20] on sexually exploitive physicians. A recent article by Sealy[21] on sex addiction and dual-diagnosis patients may be helpful to physicians who are new to this type of patient. In addition, screening instruments have been developed that can be useful in the assessment of the disorder.

Resources that are available to treat compulsive sexual behavior have increased dramatically in the last decade. The National Council on Sexual Addiction and Compulsion provides a nationwide network of treatment facilities as well as individual therapists. Twelve-step programs have been developed to support and encourage appropriate sexual behavior. In addition, there are now Web sites offering recovery, clinical resources and extensive bibliography information. See Table 5 for a listing of resources and their contact information.

**Table 5. Support Organizations for Compulsive Sexual Behavior**

*The National Council on Sexual Addiction and Compulsion (NCSAC)*
1090 Northchase Pkwy, Suite 2008, Marietta, GA 30067; (770) 989-9754; www.NCSAC.org

*American Foundation for Addiction Research (AFAR)*
PMB 321, 3722 W 50th St, Minneapolis, MN 55410; (612) 915-9454
www.AddictionResearch.com

*Sexaholics Anonymous (SA)*
PO Box 111910, Nashville, TN 37222-1910; (615) 331-6230; www.SA.org

*Sex and Love Addicts Anonymous (SLAA)*
National Office, PO Box 119, New Town Branch, MA 02258; (781) 255-8825

*Recovering Couples Anonymous (RCA)*
PO Box 11872, St Louis, MO 63105; (314) 397-0867; www.Recovering-Couples.org

*Carnes, P.J., CNS Spectrums, Vol. 5., No. 10. 2000.*

## *CONCLUSION*

The study and treatment of compulsive sexual behavior, or sexual addiction, have taken a long time to gain recognition and respect as an area of medical specialty. As with other disorders, such as alcoholism or diabetes, this disorder has presented physicians with the challenge of learning an unfamiliar field. Most physicians, who take time to learn, find patients who are profoundly grateful. In many ways, the field of sexual addiction lags behind both professional and lay awareness of alcoholism or pathological gambling. Yet, important strides are being made in both understanding and awareness. Appreciating the issues and challenges of compulsive sexual behavior

will help physicians when their patient's behavior crosses the line from problems of judgment and character to emerging as a clinical disorder.

## *REFERENCES*


[1] Carnes P. Addiction or compulsion: politics or illness? *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention. 196:3:127-150.*

[2] Stein DJ. Hugo F. Oosthuizen P. et al, Neuropsychiatry of Hypersexuality. *CNS Spectrums,* 2000:5(1):36-46.

[3] Canning M. Breaking through denial. *Sexual Addiction and Compulsivity: The Journal of Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1999:6:47-62.

[4] Delmonico D. Cybersex: high tech sex addiction? *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention. 1997:4:159-168.*

[5] Garos S. Stock W. Measuring disorders of sexual frequency and control: the Garos Sexual Behavior Index. *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1998:5:159-178.

[6] Garos S. Stock W. Investigating the Discriminant validity and differentiating capability of the Garos Sexual Behavior Index. *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1998:5:251-268.

[7] Gordon L.J. Fargason P. Kramer J. Sexual behaviors of patients in a residential chemical dependency program: comparison of sexually compulsive physicians and non-physicians with non-sexually compulsive physicians and non-physicians. *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1995:2:233-236.

[8] Sealy J. Psychopharmacologic intervention in addictive sexual behavior. *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1995:2:257-276.

[9] Blanchard GT. Differential diagnosis of sex offender: distinguishing characteristics of the sex addict. American Journal of Preventive Physiciatry and Neurology. 1990:2:3:45-47.

[10] Carnes P. Nonmaker D. Skilling N. Gender differences in normal and sexually addicted populations. *American Journal of Preventive Psychiatry and Neurology.* 1991:4:16-23.

[11] Black DW. The epidemiology and phenomenology of compulsive sexual behavior. *CNS Spectrums.* 2000:5(1):26-72.

[12] Wines D. Exploring the applicability of criteria for substance dependence to sexual addiction. *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1997:4:195-220.

[13] Carnes PJ. *Don't Call It Love.* New York, NY:Bantam Books: 1991.

[14] Griffin-Shelly E. Benjamin L. Benjamin R. Sex addiction and dissociation. *Sexual Addiction and Compulsivity: The Journal of Treament and Prevention.* 1995:2:295-306.

[15] Waston A. Cruising and using compulsive sex and substance abuse. *Professional Counselor.* 1998:13:6.

[16] Evans K. Sullivan J. *Treating Addicted Survivors of Trauma.* New York, NY: Guilford Press: 1995.

[17] Hollander E. Wong C. Body dysmorphic disorder, pathological gabling, and sexual compulsions. *J Clin Psychiatry.* 1995:6:4:10.

[18] Black DW, Kehrberg L. Flumerfelt D. Schlosser S. Characteristics of 36 subjects reporting compulsive sexual behavior. *Am J Pschiatry.* 1997:154:243-249.

[19] Carnes P. Wilson M. *Following the Obsessive Shadow: A Task-Centered, Competency-Based Approach to the Treatment of Excessive Sexual Behavior, Gentle Path Press.* Wickenburg, AZ:Gentle Path Press. In press.

[20] Irons R. Schneider J. *The Wounded Healer,* Northvale, NJ: Jason Aronson, Inc: 1999.

[21] Sealey J. Psychopharmacological intervention in addictive sexual behavior. *Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention.* 1999:2:257-276.