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18.4. Sexual Addiction

Since James Orford's classic article on sexual dependency appeared in the British Journal of Addictions in the late 1970s, there has been a growing awareness among medical professionals of sexual behavior that was problematic yet did not fit traditional categories, such as the paraphilias. In these cases, sexual behavior had similar patterns to substance abuse, pathological gambling, and compulsive eating and frequently co-occurred with these problems. Loss of control, significant adverse consequences, and continuation despite consequences emerged as beginning criteria for patient identification. Compulsive sexual patterns, coupled with extreme preoccupation, characterized patients who often incorporated diverse normal and abnormal behavior. Cultural changes worked to reveal and to accentuate the problem. Public awareness and accountability connected to sexual exploitation and harassment in religious, political, military, and business contexts generated more patients seeking help. Furthermore, the acquired immune deficiency syndrome (AIDS) epidemic brought more patients who were behaving in self-destructive ways counter to their own wishes. Finally, Internet sex dramatically escalated the frequency of patients seeking help from clinicians. Al Cooper's landmark studies reveal that 6 percent of Internet users manifest problematic online behavior. Many of those in trouble with cybersex probably would not have had a problem without the Internet. Parallel to sexual awareness, 12-step groups, such as Sex Addicts Anonymous (SAA), have grown dramatically as an adjunct to therapy.

With growing recognition of the problem, clinicians have used varying terminology depending on their professional orientation. Hypersexuality, sexual compulsivity, sexual impulsivity, sexual addiction, and nonparaphilic sex addiction have been the most commonly used terms. In the addiction field, one of the key signs of addiction is compulsive use. One of the recent formulations of that position is Alan Lesher's description of addiction as a hijacked brain. He explains addiction as a brain disease that manifests as

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SUGGESTED CROSS-REFERENCES

Related discussions include Section 18.1a on normal human sexuality and sexual dysfunctions, Section 18.1b on homosexuality, Section 32.2 on normal child development, and Section 32.3 on normal adolescent development. Transvestic fetishism is discussed in Section 18.2 on paraphilias, and intersex disorders are discussed in Section 24.6 on endocrine and metabolic disorders.

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REFERENCES


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Patrick J. Carnes, Ph.D.
compulsive behavior. In practice, some professionals may make distinctions between addiction and compulsion, others may use the terms interchangeably.

The term sex addiction has several advantages conceptually and practically. First, it discerns the difference between compulsively accessing the pleasure centers of the brain and nonpleasure behavior that is more typical of obsessive-compulsive behavior. Second, the frequency, similarity, and interaction with other comorbid addictive behaviors argue strongly for common etiology. Finally, the addiction model leads to clear-cut, successful intervention strategies, including nationwide networks of self-help support groups. Currently, an inclusive national effort is under way to develop comprehensive diagnostic criteria that are being tested on large samples for prevalence data. Researchers gathering statistical evidence by using advanced neuroimaging technology may add clarifying data about the biology of the condition, which, in turn, may redefine terminology.

PROBLEM RECOGNITION

The nature of sexually compulsive behavior interferes with problem recognition. Patients are not candid about their behavior nor are they likely to reveal that specific behaviors are actually part of a consistent, self-destructive pattern. Patients frequently hide the severity of the problem from others, delude themselves about their ability to control their behavior, and minimize the impact on others. Their shame extends to being deceptive with their physician. Sometimes, their role as leaders in church, business, community, or political settings compounds the problem, because they are expected to exhibit behavior that is beyond reproach. Usually, some event precipitates a visit to the physician. The incident is presented as a one-time event, as a moral lapse, or as an event precipitated by marital problems. Careful assessment and data assembling may reveal a much deeper pattern that requires specific therapy for sexual compulsion. These deeper patterns may emerge in diversified forms, including compulsive masturbation, compulsive prostitution, cybersex, and affairs. They may extend to include exhibitionism, voyeurism, and criminal sexual misconduct. Seldom is there just one pattern, but rather there is a collage of patterns affected by hierarchies of preference, situation, combination, and opportunity. For example, pornography on the Internet may serve as a portal to other addictive sexual behaviors, including prostitution and affairs, or it may be a gateway to solicitation and stalking of underaged girls. The following scenarios would prompt the clinician to assess the patient for the presence of sex addiction:

- **The patient volunteers a long-term pattern of problematic sexual behavior.** Usually, this occurs because the patient has hit a level of despair or is suicidal. He or she knows that he or she simply cannot continue living this way.

- **The clinician has evidence of a long-term problem.** If the patient history shows frequent consequences due to sexual acting out, a pattern may emerge. If the clinician learns of chronic affairs, and the spouse discovers evidence of pervasive prostitution use, such compulsive behavior may signal an addictive pattern.

- **Some sexual event occurs, and the clinician has evidence of other compulsive or addictive behaviors.** Patient issues with drug use, gambling, and food point to the larger problem of a loss of control. Many times these issues cooccur and amplify each other.

- **The patient’s behavior involving abuse of power should prompt a thorough evaluation.** Sex with children, congregants, employees, patients, or other persons under the authority of the patient usually involve at least a temporary removal of the person from his or her position and may require reporting in some jurisdictions.

- **Unexplained problems accompanying compulsive sexual behavior necessitate delving deeper.** Unexplained absences, failure to perform expected tasks, and the disappearance of large sums of money could result.

An inappropriate sexual incident does not always mean the presence of 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. In a recent study of sex offenders, only 72 percent of pedophiles and 38 percent of rapists fit the criteria for sexual addiction. The following cases illustrate the diversity and complexity of sexually addictive behavior:
A 71-year-old chief executive officer of a successful office products manufacturing company received two sexual harassment complaints in a few weeks. The company hired an outside investigator to do a company-wide sexual harassment audit. More than 70 women (past and current employees) came forward with stories of constant propositions, fondling, and affairs. The investigation further uncovered similar stories among vendors, trade people, family friends, and an unfortunate incident with his daughter-in-law.

By the time he was 18 years of age, a patient had been viewing Internet pornography for 10 years. He was caught viewing underage pictures by a computer repairman and was reported when he was in the eighth grade. His parents made efforts to police his Internet behavior, but he was more savvy than they were and could hide his tracks. He flunked out of his first year of college, because he was spending an average of 40 hours per week masturbating while online. His parents’ warning came when his second-semester tuition had gone unpaid. Their son had expended in strip bars all of the tuition money he had been given.

Clinicians notice that sexual compulsion surfaces in many guises. Common to them all is that patients report a loss of control and life consequences. Age or sex excludes no one. The ratio of men to women is 3 to 1, which parallels alcoholism and problem gambling. The notable exception is problematic online sexual behavior, for which 40 percent of patients are women. The Internet has also pushed boundaries: Younger and elderly people are becoming involved in compulsive cybersex. Some additional factors complete a profile that might signal a need for clinical intervention. In a large survey (N = 953), patients in recovery reported the following: Seventeen percent had attempted suicide, and 72 percent obsesssed about it because of their sexual behavior. (More than 50 percent of hospital admissions with a diagnosis of sex addiction also had significant depression.)

The majority of sex addicts (65 percent) routinely ran the risk of sexually transmitted diseases (STDs). Thirty-eight percent of the men and 45 percent of the women contracted STDs as a result of their addictive behavior.

Sex addicts recognized AIDS as the most lethal complication of their illness. (Yet, a recent University of Georgia study revealed that, although 87 percent of health practitioners were aware of sexually compulsive behavior, only 13 percent screened for human immunodeficiency virus [HIV].) Many sex addicts have lost a partner or spouse (40 percent) and most have experienced severe marital or relationship problems (70 percent) because of their behavior.

Female sex addicts report deep grief over abortions (36 percent) and unwanted pregnancies (42 percent). More than 58 percent reported severe financial consequences. Some reported losing the opportunity to work in the career of their choice (27 percent). Most sex addicts (79 percent) talk of serious losses in job productivity; 11 percent were demoted. Thirty-eight percent experienced some physical injury as part of sexual acting out. Nineteen percent of the men and 21 percent of the women were involved in automobile accidents as part of acting-out behavior. Sixty percent of the women were physically abused during sex; 50 percent were raped. Men also reported physical battering (16 percent) and dangerous situations (44 percent). Sixty-five percent reported sleep disorders related to shame, fear, and despair over their behavior.

Mary L. Gannon and other specialists have made the case that, each year, urologists, surgeons, gynecologists, and emergency room physicians examine patients who have self-inflicted genital trauma or who have inserted objects into their urethras, bladders, rectums, and external genitalia. These patients have experienced serious injury due to unusual or risky sexual practices. Sex addiction specialists routinely do grand rounds for these specialties, because they quickly become primary referents.

Etiology

Addiction is a complex biosocial illness. More than 87 percent of sex addicts also report having other addictions, which add to the complexity. Searching for the biological precursors has been a touchstone of addiction medicine research. Many hypotheses are being explored to explain susceptibility to multiple avenues of addiction and compulsion. For example, addiction researchers have noted that the Taq 1A1 allele of D2 receptor gene is associated with increased risk of alcoholism, drug abuse, smoking, obesity, compulsive behaviors, and Tourette’s syndrome. Although sex addiction is relatively new in attracting researchers’ interest at this level, it has been clearly shown that sex addicts come from families with multiple addictions. For example, 22 percent of mothers, 40 percent of fathers, and 56 percent of siblings are known to have more than one addiction.

A clear picture has emerged in families of sex addicts in addition to the presence of addictive pathology. Using assessments based on the circumplex model of family systems, most addicts come from families that are rigid (77 percent). These families are characterized by extreme efforts to control and minimal negotiation. Offspring from this family type often have difficulty with accountability and authority. They are also prone to secrecy lives out of the purview of the family. This double-life phenomenon is especially strong when adolescents discover that parents do not live up to their proclaimed values. If parents proclaim sexual fidelity, for example, and that turns out to be untrue, it deepens defiance and secrecy. These families also tend to have negative attitudes toward sexuality in general, which tend to increase shame and obsession.

Sex addicts also tend to originate in disengaged families (87 percent). This family type makes a great effort to look good for appearances but has little intimacy. Family members are “ships passing in the night.” Some have argued that addiction is a result of a failure to adequately bond. Mark F. Schwartz and colleagues, using an attachment perspective, propose that sex addiction is, in fact, an intimacy disorder. The net effect is that these patients do not trust relationships. More than two-thirds of these patients come from families that are rigid and disengaged. The challenge in treatment is that they trust authority and accountability, and they have little confidence in relationships or intimacy. The difficulties that propel them into addiction become the factors that make them difficult to engage in therapy.

Trauma also appears to contribute to sex addiction. Eighty-one percent report a history of sexual abuse, 72 percent report a history of physical abuse, and 97 percent identify various forms of emotional abuse. One study by Patrick J. Carnes and David Delmonico shows that the amount of physical and sexual abuse is a substantive factor in the number of addictions as an adult. Addiction becomes a solution for the distress of the reactivity that typifies posttraumatic stress disorder (PTSD). Bessel van der Kolk and others point to the neurochemical shifts that occur in which trauma victims actually repeat their trauma compulsively. Clinicians note that sex addicts incorporate significant scenarios and even actual behaviors from their abuse experiences into their acting-out cycles. Ken Adams
and others point to enmeshment with specific parents (surrogate spouse) and covert eroticization as common phenomena in sex addiction.

Another common pattern is high-risk behaviors that result in severe consequences, such as loss of career or arrest. Children who were 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. One of the most common stories that clinicians hear are sex addicts who knew that their behavior would be disastrous but did it anyway. An example is an addict who strongly believes that the street prostitute is a police decoy and notices a squad car down the street but proceeds to solicit sex anyway.

Onset of sex addiction also appears to be triggered by stressful events. Addicts report this stress in terms of specific events (deaths, accidents, severe losses, and trauma) or catalytic or specific demanding environments (medical school, seminary, and developmental business). Catalytic events and environments activate trauma memories and compulsive behavior. Addiction also appears to be a repression mechanism, because, when behaviors stop, memories of abuse begin to return. Most clinicians also notice an extreme ability to compartmentalize and to dissociate from reality, which becomes incorporated into addictive behavior as part of escapism. Family systems and rules that result in secrecy combined with trauma survivors' capacity to compartmentalize are the building blocks of the addict's secret life.

The result is an implicit dishonesty and failure to live up to values, which creates a chronic sense of shame. Almost all addicts admit to strong feelings of guilt and shame (96 percent), strong feelings of isolation and loneliness (94 percent), feelings of hopelessness and despair (91 percent), and acting against personal values and beliefs (90 percent). Merl A. Fossom and Marilyn Mason created a conceptual framework to explain the role of shame in binge-and-purge behavior across all addictions. The inability to meet personal standards leads to an acting-in mode that calls for extreme abstinence. Because of these excessively high standards, there is progressive acting out. A good example is clergymen who preach against promiscuity or some sexual behavior only to be discovered engaging in that behavior or being arrested for it. Investigation reveals a chronic pattern of that behavior. In public pronouncements, they are purging, and, in private behavior, they are binging. This dichotomy underlies the coalesces of shame and compartmentalization. A hospital-based survey of sexual disorders revealed that 72 percent of sex addicts identified with a binge-and-purge pattern.

Comorbidity Few of these patients have only a sexual problem. For example, 41 percent have problems with drugs or alcohol, and 38 percent have an eating disorder. Other problems include pathological gambling,nicotine abuse, and compulsive working. In addiction medicine, the term addiction interaction is used to describe how addictions more than coexist but actually reinforce or amplify one another. Frequently, the term fusing is used when two addictions are almost always used at the same time. An example would be cocaine and sex addiction. Arnold Washton and others have documented that 50 to 70 percent of cocaine addicts also exhibit sexually compulsive behavior. Most acquisition of cocaine is connected to some form of sexual behavior. One frequent subset is an addict combining cocaine and extended masturbation, which lasts as long as 15 to 20 hours. Patients report that the goal is not to ejaculate, because that brings a severe migraine-like headache. Rather, the goal is to preserve this feeling. These patients fuse their behavior. They never masturbate without cocaine; they never use cocaine without masturbation.

Other examples of interaction would include

- Using alcohol to disinhibit for specific high-risk sex
- Combining the hyperventilation of tobacco smoke and compulsive masturbation
- Arousal activities, such as risky sex and amphetamines or crystal meth followed by numbing activities, such as overeating, alcohol, and masturbation (a common scenario of PTSD victims)
- Merging of cruising rituals to pick up partners and drinking (bars) or drug using (raves and dances)
- Going to a topless casino to drink, to gamble, and to be sexual

Compulsive spending and debts (sometimes part of a cluster of behaviors called the financial disorders) are frequently noted (27 percent). Although many have experienced great financial losses as part of their sex addiction, some actually eroticize money. For example, it is estimated that 1.6 million men use prostitutes compulsively. Of men seeking treatment, two-thirds report significant financial problems related to prostitution. Patients are able to tell the clinician the dollar amount of cash or credit that precipitates acting out. The financial issues in many cases extend beyond their sexual behaviors. They frequently spend more than they can afford or earn and amass significant debts as a result. These patients need help beyond treatment for their sexual disorder.

Sexual aversion (International Classification of Diseases diagnosis number 302.79) also is a common problem that may seem ironic, given the amount of sexual experience that these patients have. Usually, it is trauma and family related. One pattern is long periods of binging followed by long periods of sexual abstinence. Another common issue is binging outside of a primary relationship (usually with high-risk or unknown people) but being compulsively nonsexual within the relationship. Sexual avoidance also appears in spouses of sex addicts, providing the addict with an excuse for outside activities. Sexual aversion and addiction parallel the eating disorders in that the extremes and binging and purging are a family of issues with common etiology. Similarly, in the case of food disorders, one does not give up food but learns how to eat differently. The clinical risk of undiagnosed aversion is that patients slip into sexual avoidance, as opposed to focusing on sexual health for themselves. Usually, compulsive sexual behavior is part of an intricate weave of addictive and avoidant behaviors to manage internal distress.

Sexual Behavior Patterns In 1985, an extended survey of more than 170 behaviors revealed that sex addicts tended to cluster into ten distinct types of behavior. These typologies have a specific erotic focus that seems to correlate with distinct phases of courtship that have become disordered through the addicts' development. Table 18.4-1 summarizes these ten archetypes. They are useful to the clinician, because the behavioral clusters help reveal the addict's arousal patterns. For example, intrusive sex includes patients who compulsively use frothiness and toucherism. The goal of those behaviors is to touch people sexually without being aware of the behavior or without being caught. If they exhibit these behaviors, they are also likely to make obscene phone calls. If they make obscene calls, they also are likely to insert inappropriate sexual humor into conversations. If they are professionals, such as physicians, dentists, clergy, or therapists, they touch patients inappropriately under the guise of their professional tasks.

The clinician looks for the erotic moment. In intrusive sex, the erotic moment is to invade the space of others in ways that make it difficult for
Table 18.4-1

Sexual Behavior Patterns

<table>
<thead>
<tr>
<th>Fantasy sex: sexually charged fantasies, relationships, and situations</th>
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</thead>
<tbody>
<tr>
<td>Arousal depends on sexual possibility. Neglecting responsibilities to engage in fantasy or to prepare for the next sexual episode, or both, is common among fantasy sex addicts.</td>
</tr>
<tr>
<td>Seductive role sex: seduction of partners</td>
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<tr>
<td>Arousal is based on conquest and diminishes rapidly after initial contact. Arousal can be heightened by increasing risk or the number of partners, or both.</td>
</tr>
<tr>
<td>Voyeuristic sex: visual arousal</td>
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<tr>
<td>The use of visual stimulation to escape into an obssessive trance. Arousal may be heightened by masturbation, risk (e.g., peeping), or violation of boundaries (e.g., voyeuristic rape), but, for arousal to be maintained, it must be illicit somehow and must be visual.</td>
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<tr>
<td>Exhibitionistic sex: attracting attention to the body or sexual parts of the body</td>
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<tr>
<td>Sexual arousal stems from reaction to viewer shock or interest.</td>
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<tr>
<td>Paying for sex: purchase of sexual services</td>
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<tr>
<td>Arousal is connected to payment for sex, and, with time, the arousal actually becomes connected to money itself. Payment creates an entitlement and a sense of power over meeting needs, but the arousal starts with having money and the search for someone in the business.</td>
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<tr>
<td>Trading sex: selling or bartering sex for power</td>
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<tr>
<td>Arousal is based on gaining control of others by using sex as leverage.</td>
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<tr>
<td>Intrusive sex: boundary violation without discovery</td>
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<tr>
<td>Sexual arousal occurs by violating boundaries with no repercussions.</td>
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<tr>
<td>Anonymous sex: high-risk sex with unknown persons</td>
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<tr>
<td>Arousal involves no seduction or cost and is immediate. The arousal has no entanglements or obligations associated with it and occurs at any time and often in unsafe or high-risk environments, such as bars, beaches, parks, and restrooms.</td>
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<tr>
<td>Pain exchange sex: being humiliated or hurt as part of sexual arousal or sadistic hurting or degrading another sexually, or both</td>
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<tr>
<td>Arousal is built around specific scenarios or narratives of humiliation and shame.</td>
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<tr>
<td>Explosive sex: exploitation of the vulnerable</td>
</tr>
<tr>
<td>Arousal patterns are based on target types of vulnerability. Certain types of vulnerable persons (e.g., clients or patients of professionals, children or adolescents, or distressed persons) become the focus of arousal.</td>
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</table>

people to react or to hold the addict accountable. Empirical evidence shows that the behaviors are related. For the clinician, it becomes a guide to the internal world of the addict. In intrusive sex, the courtship distortion has to do with fear of rejection and having somehow to steal sex, even in fleeting ways. It also reveals eroticized anger, common in sex addiction, whereas the patient notices the sex but not the anger. |

Sex addicts are often active in more than one cluster of behaviors. They may, in fact, shift focus. An exhibitionist who wishes to arrest may go to a massage parlor, because it is a safer place to be seen. Compulsive affairs may replace prostitution. Most often, there is a variety of ways to act out, including paraphilic and offending behaviors. One of the distinct advantages of the addiction paradigm is that it allows clinicians to see that not only do currents of compulsive behavior transcend specific categories, but they also have the same common self-destructive results and observational purposes. The key for clinicians is to understand the escalation factor. Addicts act out using more of the behaviors, add risk and danger, or seek new behaviors, often with great risk and danger. Escalation is tempered with plateaus, efforts to reduce risk, and sexually aversive periods. Most addicts are able to pinpoint moments of escalation and resulting consequences.

Core to the treatment process is identification of the arousal template. In 1985, John Money used the term love map to describe the internal guide as to what was erotic. This arousal template is more dynamic than a map, for it usually contains a scenario based on an abuse experience, a fantasy, or something historical. Clinicians approach this issue by having the patient identify the ideal fantasy—acting out were perfect, what would it look like? Therapy is about tracing back the origins of the arousal, understanding its functional and dysfunctional parts, and reimagining healthy sexual practice. In this way, the organizing principles of the compulsion are exposed and, with psychological distance, can lose their power.

**Cybersex: Crack Cocaine of Sex Addiction** One of the greatest escalating of sexual addiction is the Internet. Cybersex has been termed the crack cocaine of sex addiction. In 2002, sex-related sites became the number one economic sector of the Internet, recording sales that exceeded that of software and computers. Pornography alone has become a problem in the workplace. Seventy percent of Internet pornography traffic occurs between 9 AM and 5 PM. Seventy-two percent of companies that have faced Internet misuse reported that 69 percent of those cases were related simply to pornography. Leading software publishers estimate as much as $3 billion dollars per year in lost productivity for American companies. Serious researchers showed in large samples that one in six employees was now having trouble with sexual behavior online.

Researchers have noted problems with compulsive and addictive behavior online, especially in the areas of gambling and sexuality. Others have noted behaviors such as online trading, gaming, and compulsive computer use. In addition to Cooper's original articles, others who work with compulsive sexual behavior patients documented problematic online sexual behavior in which people's daily ability to function was being affected by their cybersex activities. Specific patterns of arousal emerged in these online compulsive scenarios. Among them were:

**Rapid escalation of amount and variety**. Patients report consistently that they experienced a rapid increase in the amount of behavior and the diversity of sexual behavior. People who have significant problems often find that the problems start almost immediately. Consider the clergyman who started viewing pornography on July 4th. By the time he was discovered only 5 weeks later, he had already embezzled 8,000 dollars from the church to pay for his online activities. That pattern, although not true of all cases, is common enough to be noticed by clinicians. Factors that contribute to escalation include the appearance of anonymity and ease of access. Also, a pattern of denial quickly emerges in which the behavior is seen as having no consequences, even though clear consequences are inevitable (such as discovery of embezzled funds).

**Escalation becomes obsessive, with new, specific behaviors becoming quickly fixed**. Patients report that they become obsessed with specific behaviors that they had never experienced or even knew of before their Internet experiences. This pattern is intriguing, given that sexual science has long taken the position that the arousal template or love map is established early. John Money suggests that arousal patterns are firmly established between 5 and 11 years of age. Patients, however, report being unable to stop thinking about behaviors that they did not know existed until they were in their 60s and on the computer. Thus, under the influence of the computer, users are experiencing high degrees of arousal of which they have no history and that are difficult to stop. This finding also counters much of the traditional addiction and compulsion literature that traces obsessive behavior in adults to experiences of childhood or adolescent sexual abuse.
Relational repression occurs, in which absorption in Internet sexual activities results in serious withdrawal from sexual contact with partners and withdrawal from overall intimacy. Patients report that sex with spouses or partners declines in frequency and appeal. Furthermore, they note a withdrawal from social contact with family, friends, and colleagues. In part, that is a result from many hours spent on the computer and the emotional depletion that accompanies Internet binging. There also appears to be a shame component that leads to isolation and despair. Although some have reported that pornography in general leads to a decline in intimate sexual interaction, the intimacy avoidance with cybersex appears to be quite profound and needs to be studied systematically.

Internet sexual behavior can accelerate existing addictive and compulsive behavior and can precipitate new compulsive off-line behavior. A common finding is that patients who are already having trouble with compulsive sexuality found the Internet to be a significant behavior intensification catalyst. The Internet not only intensifies the problematic eroticization but also adds new resources. If compulsive prostitution was a problem, it became even more so as a result of Internet activity. Some patients report having had no history of compulsive sexual behavior until they discovered the Internet. When their sexual behavior escalated online, they started behaviors off-line that became compulsive as well.

One theory of explanation for escalation, intensity of arousal, and compulsive behavior is that, through the Internet, patients access the unresolved. All people have sexual experiences that leave them unfinished. Sexual play as a child, for example, may leave a person with unfinished experiences. As a person matures, he or she realizes that he or she no longer has an interest in that behavior or that those experiences are no longer appropriate for adults. Yet, a person might experience the right image or story that is an absolute overlay of something unfinished from childhood or adolescence. The nature of marketing for pornography sites is to bombarding potential clients with a variety of images to stimulate the purchase of memberships. When that which is unfinished is accessed, the individual begins to search for more of the same genre. The marketing loops of sex sites are literally labyrinthine; each choice may bring a person closer to the types of images that most closely fit that unresolved, unfinished aspect of the sexual self. Patients often report the phenomenon of a burned-in image—a specific scene out of their Internet experience about which they cannot stop thinking. This phenomenon is similar to the intrusive images that PTSD patients describe. Patients report that preoccupation with a specific image became so troublesome that they would delete it from their files only to go back to the original source and retrieve it. This happens over and over again.

Differential Diagnosis

Summarizing the previously stated material, sex addiction patients are characterized by being in some type of sexual crisis. They are typically distrustful of authority, have significant intimacy deficits, and have a history of some type of trauma. Their behavior patterns are hidden and varied but are extensive. Their sexual behavior is clouded by other cooccurring addictions and compulsions. There is a history of crises and consequences around the patient's sexual behavior. Many times, the therapist literally has to be like a detective piecing together the story, because it comes in classic dubs and drabs.

Two principles are extremely important at this stage. First, if there is any written complaint (lawsuit, arrest record, or company harassment complaint), it is critical to review these documents with the patient. This saves time and discovery effort. Second, if there are family members involved, they often have a wealth of data, which add to the picture. Interviewing family members independently may reveal significant gaps and inconsistencies in the patient's story, adding depth and insight to the impact of the patient's behavior.

Currently, there is a large-scale effort to validate diagnostic criteria and to collect prevalence data. Sponsored by the Compass Point Addiction Foundation, this project was initiated in 2001 and is scheduled to be completed in 2005. Strong position statements were made for different conceptualizations of this disorder, including statements by Aviel Goodman who termed it addiction, Mart Kafka who used the term nonparaphilic hypersexuality, Reid Finlayson who called it problematic hypersexuality, Eli Coleman who argued for compulsive sexual behavior, and William Marshall and William Marshall who used the term excessive sexual desire disorder. Terminology aside, remarkable agreement exists on the basic elements of loss of control, continuation despite consequences, and obsession.

The term sex addiction does not appear in the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). However, the criteria listed for various addictive disorders, such as substance dependence and pathological gambling, can be condensed into the same three key elements: (1) loss of control (compulsivity): "There is a persistent desire or unsuccessful efforts to cut down or control substance use”; the patient "has persistent unsuccessful efforts to control, cut back, or stop gambling." (2) Continuation despite adverse consequences: "The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance use"; the patient “has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling.” (3) Obsession or preoccupation: "A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects”; the patient “is preoccupied with gambling.” When a set of sexual behaviors fulfill the same three criteria, the person can be considered to have a sexual addiction. Note that tolerance and withdrawal are not mentioned in this discussion. Many drugs of abuse are not associated with tolerance and do not have specific withdrawal symptoms, so these features are not essential for the diagnosis of addiction.

However, many clinicians have noted withdrawal symptoms parallel to those experienced by cocaine addicts in withdrawal, including extreme irritability, sleeplessness, and anxiety. Usually, these patterns intensify and then wane over a 3-week period.

The value of the addiction model is that it leads to a specific treatment approach, which is described in the following discussion. For many affected patients, the more traditional treatments, such as psychoanalysis, insight-oriented therapy (in the belief that once the behavior is understood, it stops), or even punishment (such as incarceration), have failed. It is well accepted that psychotherapy for alcohol dependence is likely to fail until the drinking problem has been directly addressed and stopped. The addiction model posits that the same is true for many persons whose sexual behavior is compulsive.

Any sexual activity can be compulsive, including those considered normal and healthy, such as masturbation and consensual sexual intercourse. However, some sexual behaviors are considered abnormal. These are listed in the DSM-IV-TR under the heading of paraphilia. The chief feature of a paraphilia is that which is desired sexually is objectified: What matters is the particular body part (e.g., a foot), item of clothing (e.g., an underwear), or age (e.g., a child), or a sequence of activities. These behaviors may be episodic, situational, or compulsive. They also may reflect culture, disordered courship patterns, and perversion (arousal dependent on rule breaking). Thus, sex addiction might include paraphilia. Because someone
has an unusual preference does not mean that an addictive or compulsive behavior is present.

Another major advantage of the addiction approach is that such patients tend toward many types of sexual activities, normal and abnormal. They engage in several behaviors simultaneously or in a specific hierarchy of preference. Clinical diagnoses based on specific behaviors such as the paraphilias miss the dynamic and interactive quality of patient behavior patterns. Nor do the paraphilias account for normal behaviors that have become excessive, self-destructive, or dysfunctional. Addiction manifested in compulsive behavior extends through paraphilic and nonparaphilic, abnormal and normal, perverse and diverse.

John Sealey, Kafka, and others have observed the importance of pharmacological interventions, which have helped reduce patient symptoms. Monoamine neurotransmitters such as serotonin, norepinephrine, and dopamine serve a modulatory role in human and mammalian sexual motivation, appetitive, and consummatory behaviors. Pharmacological agents that enhance serotonergic and dopaminergic function have been shown to be helpful to patients in reducing obsession, modifying behavior, and utilizing therapy. Monoamine neurotransmitters have long been associated with other compulsive behaviors, including compulsive drug use, gambling, and eating. The addiction model has long defined addiction as present when there is compulsive behavior. Carnes has also made the case that not only does sex addiction involve multiple sexual behaviors, but it is highly interactive with other comorbid disorders that have common underpinnings.

Historically, clinicians have used criteria similar to those used for substance abuse and pathological gambling. These criteria are based on the three standard principles of evaluation of addictive disorders as listed previously. Ten elaborated criteria are used. Table 18.4–2 summarizes those criteria. Two data sets are supplied: (1) patients who identified with the specified criteria on admission to an impatient sex addiction program and (2) patients who had been in recovery for a substantial amount of time. The patients who had been in recovery over time reported higher correspondence with the criteria.

Other diagnoses must be considered in the differential diagnosis of excessive sexual activity, including the following:

- Impulse control disorders
- Bipolar affective disorder
- PTSD
- Adjustment disorder (a temporary change of behavior)
- Substance-induced disorders
- Dissociative disorders
- Delusional disorders (Erotomania)
- Obsessive-compulsive disorder (OCD)
- Gender identity disorder
- Delirium, dementia, or other cognitive disorder
- Personality disorders

A number of authors (Jennifer P. Schneider, Richard R. Irons, John Sealey, and Nancy Raymond) have described how these disorders can be expressed as excessive sexual behavior. For example, a hypersexual patient who is in the manic phase of bipolar illness usually demonstrates other features of the disorder, such as grandiose thinking, rapid speech, excessive activity, and short attention span. A person whose sexual behavior has been disinhibited by a high concentration of alcohol in the brain is likely to exhibit other signs of intoxication. A patient whose sexual behavior has been disinhibited by Alzheimer's disease shows other cognitive deficits. As for adjustment disorder, this is a temporary situation related to current stresses or events in a person's life. For example, a person who is in the midst of a divorce may demonstrate significant, but temporary, behavior changes. In contrast, addiction is a pervasive pattern of behavior that is present for months and years.

Finally, characterological disorders can be the primary cause of excessive sexual behaviors. For example, persons with antisocial or narcissistic personality disorder may have sexual contact with multiple partners, but the reason is that the other person is viewed simply as an object to be used for one's own sexual pleasure, not because there is loss of control.

### Table 18.4–2
Diagnostic Criteria and Patients in Initial and Long-Term Treatment Who Fit These Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Initial Treatment (%)</th>
<th>Long-Term Duration (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent failure (pattern) to resist sexual impulses to engage in specific sexual behavior</td>
<td>73</td>
<td>94</td>
</tr>
<tr>
<td>Frequent engaging in those behaviors to a greater extent or over a longer period of time than intended</td>
<td>66</td>
<td>93</td>
</tr>
<tr>
<td>Persistent desire or unsuccessful efforts to stop, to reduce, or to control behaviors</td>
<td>67</td>
<td>88</td>
</tr>
<tr>
<td>Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experiences</td>
<td>58</td>
<td>94</td>
</tr>
<tr>
<td>Preoccupation with the behavior or preparatory activities</td>
<td>37</td>
<td>77</td>
</tr>
<tr>
<td>Frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations</td>
<td>52</td>
<td>87</td>
</tr>
<tr>
<td>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</td>
<td>63</td>
<td>85</td>
</tr>
<tr>
<td>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</td>
<td>36</td>
<td>74</td>
</tr>
<tr>
<td>Giving up or limiting social, occupational, or recreational activities because of the behavior</td>
<td>51</td>
<td>87</td>
</tr>
<tr>
<td>Distress, anxiety, restlessness, or irritability if unable to engage in the behavior</td>
<td>55</td>
<td>98</td>
</tr>
</tbody>
</table>

Courtesy of P. J. Carnes, Ph.D.

### TREATMENT PROCESS

Carnes headed a research team and initiated a study in the mid-1980s in an effort to understand recovery from sexual compulsion. 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. The team 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 based on changes in quality-of-life variables. (See Table 18.4–3 for a summary of findings.)
Table 18.4-3
Categories of Recovery over Time

<table>
<thead>
<tr>
<th>Worse</th>
<th>Yrs 2 and 3</th>
<th>Yr 3 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second 6 Mos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapse</td>
<td>Financial situations(^a)</td>
<td>Healthy sexuality</td>
</tr>
<tr>
<td>Health status</td>
<td>Coping with stress(^a)</td>
<td>Primary relationships</td>
</tr>
<tr>
<td></td>
<td>Spirituality</td>
<td>Life satisfaction</td>
</tr>
<tr>
<td></td>
<td>Self-image</td>
<td>Relationship with family of origin</td>
</tr>
<tr>
<td></td>
<td>Career status(^a)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friendships(^a)</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Continued to improve after 3 years or more.

Courtesy of P. J. Carnes, Ph.D.

First 5 Years of Recovery

First Year In the first year, there was no measurable improvement, and, yet, most sexual addicts reported that life was “definitely better.” The apparent contradiction might be explained by one respondent’s comment: “When you are hitting your head against the wall, even stopping the hitting helps.” According to the research team’s assessments, some aspects of functioning actually became worse. Most slips tended to occur in the second 6-month period of recovery. Furthermore, all health indicators—accidents, sickness, and visits to physicians—showed 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 the addicts were 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. Those indicators reflected a period of intense personal work, which resulted in more productivity, stability, and a greater sense of well-being.

Beyond Year Three 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. Approximately 13 percent 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 of the recovery process. Most importantly, 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) The sexual addict’s problems mount and create an awareness that something needs to be done. The person may seek therapy or may attend a 12-step group and 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 to 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 and Decision Stage (1 Day to 3 Months) At some point, the addict crosses a line at which 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 an STD, a spouse (or partner) leaving, a positive human immunodeficiency virus test, a sexual harassment lawsuit, loss of a professional license, an auto 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 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 (AA) of “being sick and tired of being sick and tired” and became willing to go to any lengths to get better.

Shock Stage (First 6 to 8 Months) Once they admit 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 to 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 and a 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 appropriate at this point. They report feelings of relief and acceptance once the double life is over.

Grief Stage (Second 6 Months of First Year) As they emerge further from their shock, patients become aware of 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 ceases 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 explain why the relapse rate was so high during this time period in this study.

Repair Stage (18 to 36 Months) Sexual addicts who successfully negotiated the rigors of the previous stage move from 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, whereas first-order change is characterized by using old solutions with greater energy (trying harder). However, when the paradigm changed, 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...
Table 18.4-1  Treatment Choices of 190 Persons Asked to Note the Helpfulness of Various Treatment Options

<table>
<thead>
<tr>
<th>Type of Treatment</th>
<th>Helpful (%)</th>
<th>Not Helpful (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Outpatient group</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>After care (hospital)</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Individual therapy</td>
<td>65</td>
<td>12</td>
</tr>
<tr>
<td>Family therapy</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Couples therapy</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>Twelve-step group (for sexual addiction)</td>
<td>85</td>
<td>4</td>
</tr>
<tr>
<td>Twelve-step group (other)</td>
<td>55</td>
<td>8</td>
</tr>
<tr>
<td>Sponsor</td>
<td>61</td>
<td>6</td>
</tr>
<tr>
<td>Partner support</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Higher power</td>
<td>87</td>
<td>3</td>
</tr>
<tr>
<td>Friends’ support</td>
<td>69</td>
<td>4</td>
</tr>
<tr>
<td>Celibacy period</td>
<td>64</td>
<td>10</td>
</tr>
<tr>
<td>Exercise and nutrition</td>
<td>58</td>
<td>4</td>
</tr>
</tbody>
</table>

Courtesy of P. J. Carnes, Ph.D.

and to work to meet them. A common thread in this study was the deepening of new bonds with others. Sexual addicts also reported efforts to complete projects (e.g., degrees, projects, and work) and to be dependable (e.g., being on time, following through, and responding to requests).

Growth Stage (2 Years Plus) As sexually compulsive persons achieve more balance in their lives and a greater sense of themselves, they become more available to others. Relationships with partners, friends, children, and family go through a period of renewal. More, 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 had 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. The participants were also asked to indicate anything else that they had tried and whether that, too, was useful. Table 18.4-4 summarizes the results of this portion of the survey. A number of factors stood out as being helpful in recovery, including the following:

- Inpatient treatment
- Group treatment
- 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

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 perceptions about measuring outcomes. For example, completing steps 1 through 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 Figure 18.4-1 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 at which the family, the employer, or the legal system is involved, all the data should be gathered. To rely on the patient alone with respect to 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 that 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 is a repetitive set of recurring sexual events in which there is significant loss of control. This pattern may be punctuated with periods of sexual aversion followed by bingeing. 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 and 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 outpatient settings, particularly if they are suicidal or are at 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 is 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 18.4-5). 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 the patient and the physician an awareness of the extent of the problem. The physician’s inquiry helps the patient understand the severity of the problem, and the physician must likely be less surprised by unpleasant disclosure that occurs later in therapy; however, sometimes surprises happen regardless of what preventative measures are taken.

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 from which patients can obtain such infor-
FIGURE 18.4-1 Diagnosis and treatment pattern for compulsive sexual behavior.

Presentation of Sexual Issues

In-depth Sexual History Data From Family/Employer

Pattern

Situational

Compulsive
* Repetitive Cycles
* Efforts to stop
* Resulting life problems

Other Mental Issues
* Mood disorders
* Anxiety disorders
* Abnormal personality traits
* Other addictions

Impatient
* Suicidality
* Failure to stop
* Risk to self or others

Outpatient
* Commitment to therapy
* Support of family
* Periods of abstinence from self-destructive sexual behavior

Three Phases of Treatment

- **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, his or her partner must also commit to this process. This period is designed to reduce sexual chaos and to teach how sex has been used as a

<table>
<thead>
<tr>
<th>Table 18.4-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Phases of Treatment</td>
</tr>
<tr>
<td><strong>Phase I: Intervention</strong></td>
</tr>
<tr>
<td>Survey extent of problematic behavior</td>
</tr>
<tr>
<td>Teach about illness</td>
</tr>
<tr>
<td>Referral to 12-step program</td>
</tr>
<tr>
<td>Confront denial</td>
</tr>
<tr>
<td>Agree on behavior contract</td>
</tr>
<tr>
<td><strong>Phase II: Initial treatment</strong></td>
</tr>
<tr>
<td>Twelve-step program attendance</td>
</tr>
<tr>
<td>Complete first step of 12-step process</td>
</tr>
<tr>
<td>Agree on writing an abstinence definition</td>
</tr>
<tr>
<td>Written relapse prevention plan</td>
</tr>
<tr>
<td>Complete a period of celibacy</td>
</tr>
<tr>
<td>Develop a sex plan</td>
</tr>
<tr>
<td>Partner and family involvement</td>
</tr>
<tr>
<td>Multiple addiction assessment</td>
</tr>
<tr>
<td>Trauma assessment</td>
</tr>
<tr>
<td>Group therapy</td>
</tr>
<tr>
<td>Shame reduction</td>
</tr>
<tr>
<td><strong>Phase III: Extended therapy</strong></td>
</tr>
<tr>
<td>Complete steps 2–4 of 12-step process</td>
</tr>
<tr>
<td>Developmental issues</td>
</tr>
<tr>
<td>Family-of-origin issues</td>
</tr>
<tr>
<td>Crief resolution</td>
</tr>
<tr>
<td>Marital and family therapy</td>
</tr>
<tr>
<td>Career issues</td>
</tr>
<tr>
<td>Trauma therapy</td>
</tr>
</tbody>
</table>

mation. 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 areas. Clearly self-destructive behaviors, 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 from which the patient will abstain while in therapy. For example, if exhibitionism in a shopping center is a problem, or if compulsive use of prostitutes occurs in a certain area of town, the patient agrees not only to refrain from these behaviors, but also 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 used at this time (during the first 4 to 8 weeks of treatment) for inpatient or outpatient treatment:

- **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 in the support group and in therapy.
- **Written abstinence statement.** This is a carefully scrutinized list with three parts: (1) the destructive behaviors from which the patient agrees to abstain, (2) the boundaries needed to avoid those behaviors, and (3) a full statement of the positive sexual behaviors that 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 or events that activate patient's rituals and addiction obsession) and precipitating situations (e.g., extreme stress or a fight with spouse) that are not directly related to sex, as well as performing addiction fire drills (i.e., automatic responses to prevent relapse).
coping mechanism. It also creates a window in which patient and partner can explore conceptually what constitutes sexual health. Often, during this period, the patient experiences 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 denial, but also to help those close to the patient engage in therapy for themselves.

- **Multiple addiction assessment.** Addictions and compulsions work together in various ways. The therapist helps the patient 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 patient. This assessment helps clarify the goals of long-term therapy. For many patients whose behavior stems from early abuse, this becomes the key to understanding their behavior as the acting out of a scenario and provides important psychological distance from the addictive pattern.

- **Group therapy.** Patients participate in an ongoing group. Optimally, this would be a group whose members 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 in using various strategies to reduce 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 desensitize reactivity and to defuse sexual triggers to inappropriate behavior is required. Furthermore, physicians find substantial amounts of unresolved grief, which requires attention. As noted previously, sometimes grief leads to lapses into old behavior patterns. Untended 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, Cames and colleagues found that only 23 percent of patients actually completed steps 1 through 9 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. Helping professions, including physicians and clergy, also require special intervention and monitoring.

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.

### Suggested Cross-References

Normal human sexuality and sexual dysfunctions are discussed in Sections 18.1a and 18.2. Substance-related disorders are discussed in Chapter 11, and mood disorders are discussed in Chapter 13.

### References


