

The Challenge of Treating Compulsive Sex

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In 1983, Dr. Patrick Carnes formally introduced the concept of sexual addiction to the world in a text entitled *Out of the Shadows*. Since then the field of sexual addiction and compulsive sexual behavior has developed dramatically. Terms such as addiction, compulsivity, hypersexuality, and Don Juanism all have been used to describe what generically could be called "out of control sexual behavior." Regardless of its name, clinicians from all fields agree that a syndrome exists in which individuals have a sense that they have lost control over their sexual behavior.

Only recently have clinicians begun to prepare methods for assessing and treating this complex problem, although screening and assessment instruments have been developed at a minimal level. The American Foundation for Addiction Research has undertaken the task of developing a comprehensive, standardized evaluation instrument for sexually compulsive behavior. Plans include gathering normative data on the largest sample ever used. As we continue to gather data to understand this phenomenon, we must also develop an effective multi-modal approach to assessment and treatment. This article provides a multifaceted approach to evaluating, assessing, and treating individuals who exhibit symptoms of sexually compulsive behavior. The information presented here provides a structured, eclectic approach for the most effective results.

The first step

It is impossible to discuss treatment without first addressing assessment. Treatment plans and strategies cannot be developed until certain pertinent information is gathered and prioritized. One mistake often made during the assessment phase is the assumption that the problem is easily isolated and identified. Sexual compulsivity rarely, if ever, stands alone. There are often comorbid issues in sexual compulsivity such as sexual dysfunction, physiological issues, other substances or addictions, depression and anxiety, or posttraumatic stress disorder. The complex interweaving of these issues can be difficult to tease out and prioritize. Therefore, the assessment process must include a variety of tools and techniques. For example, if standardized psychological instrumentation is not used, issues such as depression and anxiety may go unnoticed and untreated. Personality disorders that could change the timing, scope, and direction of the treatment plan may be missed. The following lists critical components of a comprehensive evaluation for sexual compulsivity:

Initial Screening. It is important to remember that sexual health and deviance often are defined culturally and individually. Therefore, one purpose of an initial screening is to help determine if further assessment and intervention is warranted. For example, clients often present for treatment because they have guilt about the frequency of their masturbatory behavior. Other common presenting problems include the spouse who believes his or her partner is sexually compulsive because he or she had an affair, or wishes to engage in an unusual sexual practice. Pornography is mentioned quite often when individuals are concerned about a sexual fantasy, feeling, or behavior. None of these examples alone indicate sexual compulsivity, however, each must be considered in the context of other information gathered during the initial screening. An initial interview should be objective, non-judgmental, and include questions that help gather the data necessary to distinguish between sexual concerns and sexual compulsivity. Such questions may include: "Have you made efforts to stop the sexual behavior?" or "What consequences have you experienced as a result of your sexual behavior?"

The initial screening process should include questions that evaluate whether other behaviors or substances are problematic for the individual. Addictions typically do not occur alone, but are often a complex myriad of rituals and behaviors that must be examined closely to allow for proper intervention. Frequency and types of behavior alone are not indicators of sexual compulsivity. Schneider (1994) suggested that counselors examine the history, frequency, sense of loss of control, obsession, and consequences to help ascertain if the behavior has become problematic. The following instruments and interview instructions may be helpful in determining if sexual compulsivity is an issue:

Sexual Interview/Instruments. Specific tests for sexual history and compulsive behavior should be included as part of a comprehensive evaluation. For example, the Sexual Addiction Screening Test (SAST; Carnes, 1989) assists in screening for compulsive or addictive sexual behaviors (see Assessment Tools, page 66, this issue). Other examples include the Sexual Dependency Inventory (Carnes & Delmonico, 1994), Multiphasic Sex Inventory (Nichols & Molinder, 1984), and the Internet Sex Screening Test (ISST; Delmonico, 1997).

The sexual interview should address any sexual issues that surfaced during other testing or assessment procedures. Often, questions from various instruments can serve to stimulate dialogue between the interviewer and interviewee. The interviewer should review all pertinent and available data prior to starting the interview process. The sexual interview questions should seek to gather relevant sexual information and fill in gaps that are missing from other areas. It is useful to ask clients to complete a structured, written sexual history that includes a detailed account of all sexual behaviors since early childhood. This history can assist in determining the questions to ask during the interview. Questions to determine how the family of origin dealt with issues of sexuality are

a critical part of the sexual interview. Perhaps the most difficult aspect of the interview is to ask personal, intimate, and sometimes uncomfortable questions. However, it is imperative to address issues such as fetishes, inappropriate sexual arousal, sexual offense behavior, cybersex usage, and unusual sexual practices.

Psychiatric/Medical Work-up. A complete physical examination by a physician familiar with problematic sexual behavior should be conducted. Sexual behavior problems are not always the primary issue, but rather may be symptomatic of other underlying physiological diseases, such as dementia, brain damage, Tourette's syndrome, and others. A psychiatrist should be consulted to determine any psychiatric issues that could be addressed with medication.

Medications can also help individuals manage their sexually compulsive behavior. It is important to have a physician who understands which medication is appropriate to address sexual behavior problems. Many times, clients need several months of stabilizing medications to help them see their issues more clearly and be able to address them more appropriately.

Psychological Evaluation. Clients should be given a number of psychological assessment instruments. These instruments may include personality measures (MCMI), depression (BDI), anxiety (BAI), measures of psychopathology (MMPI), attention deficit (TOVA), and psychopathy (HARE).

These instruments may be used to help determine if any underlying psychological or emotional disorders are present. These tests should be administered in conjunction with a well-conducted psychosocial interview that covers topics such as family, legal, occupational, educational, historical, and other relevant areas. It is not uncommon to have multiple diagnoses in this population of clients, and identification of these other diagnoses will be critical to treatment outcome.

Breaking the cycle: Treatment issues

Multiple treatment modalities are the most effective way to attain long-term wellness in this population. For example, encouraging a client to attend individual therapy, group therapy, family/couple treatment, and a support group can help break through denial and build a network of support for the individual long after treatment ends. Whether or not you subscribe to the 12-step model of addiction treatment, it is important to encourage attendance at some form of support group meetings to provide the extra support often needed by the sexually compulsive.

There are five different groups for 12-step recovery from sexual behavior: Sexaholics Anonymous (SA); Sex Addict Anonymous (SAA); Sexual Recovery Anonymous (SRA); Sexual Compulsives Anonymous (SCA); and Sex and Love Addicts Anonymous (SLAA). In addition, these groups will remain long after therapy has ended and will provide a means of support throughout the individual's life. Most support groups also offer the option of obtaining a "sponsor" - someone

with whom the individual develops a long and trusting relationship, and can assist in his or her recovery efforts. It is not likely that clients will attend all modalities of treatment simultaneously; therefore, the preferred method includes group treatment, support group attendance, combined with individual sessions scheduled on a monthly or bi-monthly basis. The following are areas that must be addressed when working with sexually compulsive behavior.

Cognitive behavioral strategies

Stress and Anxiety Reduction. Sexually compulsive behaviors can very often be triggered by stress and anxiety. Certain strategies (e.g., biofeedback, stress-reduction techniques) should be employed to help clients manage their stress and anxiety levels.

Relapse Prevention. As with any addictive disorder it is important that the client intellectually understands his or her cycle, the rituals leading up to the addictive behavior, and the steps necessary in breaking the cycle. Basic psycho-educational modules around addictive and compulsive behaviors can be the foundation for future efforts in stopping these negative behaviors. They may not always fully understand and immediately integrate what they learn during this time, but they eventually will use the knowledge to prevent relapse in the future.

Celibacy (Abstinence) Contract. An initial goal in treatment should be to eliminate or minimize sexual acting out behavior. Similar to therapy with a client who has been drinking, the counselor will make little progress with an individual under the influence of sexually compulsive behavior. One technique that often can be helpful is the use of a "celibacy (abstinence) contract." Whereas the re-introduction of sexually healthy behavior is the ultimate goal, a short period of abstinence from sexual behavior can help clients become clear and focused on their problems and possible solutions. The introduction of a celibacy contract is dependent on the readiness of the client. Some clients respond well to the contract early in treatment, whereas others are too overwhelmed with the crisis to receive any benefit from brief celibacy. Clinical awareness must be used in timing the introduction of a celibacy contract. Most celibacy contracts are between 30 and 90 days in length and may be extended if the client feels he or she needs more time.

Sexual Offense Education. Since sexually compulsive behavior may involve others in the acting out, it is important to help clients learn strategies for sexual offense prevention. Providing clients with victim empathy training (a specific set of techniques applied to sex offenders) can be useful in the prevention of future intrusive or exploitive sexual behavior.

Intimacy and attachment

Grief and Loss. Celibacy can often lead directly into issues of grief and loss. When the "drug of choice" (i.e., sex) has been removed, clients may have profound feelings of loss. In many ways it is similar to experiencing a death, but in this case the death of what they have come to know as their "best friend." Initially, nothing fills the void of that loss and therapists should be prepared to help clients go through the stages of grief and loss around their behavior. Grief and loss over the sexual behavior can trigger other grief and loss issues related to past trauma and family of origin issues.

Trauma. An estimated 87 percent of sexual compulsives (Carnes, 1991) report some form of abuse or trauma in their history. The problematic sexual behaviors that clients exhibit often can be related to past trauma or abuse issues which have interfered with their intimacy and attachment development. Addressing trauma issues is a critical part of treating sexually compulsive behavior, but typically these issues are addressed only after the clients recognize their responsibility for their current behavior.

Family of Origin. Trauma issues often are tied to family of origin issues. Even when physical or sexual abuse is not present, family dysfunction can lead to difficulties in forming attachments and developing healthy, intimate relationships. These issues should be addressed after the client has been in treatment for several months.

Spirituality

Addressing issues of spirituality (different from religion) is an important and difficult task in treatment. Clients are often unaware of their spirituality because of their acting-out behaviors. However, therapeutic empathy and persistence can help clients understand the role of spirituality in developing healthy sexual attitudes, beliefs, and behaviors.

Sexuality issues

Sexual Health Plans. Clients need to be educated on healthy sexuality, and if relevant, the impact of past abuse issues on their sexual health. Many clients have a distorted view of what constitutes healthy sexuality. The therapy sessions can be utilized to help clients gain clarity concerning what values, attitudes, beliefs, boundaries, and behaviors they would include in their definition of healthy sexuality. An example of a technique is the concentric circles exercise where three circles are drawn, one inside the other (like a bull's eye).

The client then places his or her "bottom line behaviors" (sexual behaviors he or she is avoiding) in the center circle. The second circle represents possible "red-light" behaviors that may or may not be acceptable depending on his or her state of emotional or mental health. This includes behaviors that clients are not

sure are appropriate or things that may lead towards the bottom line behaviors in the center circle. Finally, the outer circle includes the client's healthy behaviors. This one visual image of three circles can help clients realize when they are in trouble and what they need to do to move closer to their definition of sexual health (Carnes et al., 2001).

Deviant Sexual Behavior. It is important that clinicians address issues of inappropriate sexual behavior. Two main categories of individuals may emerge. First are those attracted to children or adolescents. These clients often require special treatment, and in most cases, should be referred to therapists who specialize in managing clients with attraction to children or adolescents. Second, some clients have specific arousal patterns to certain objects or behaviors. These fetishes may range from articles of clothing to sadistic and masochistic types of behavior. Fetish behaviors can be extremely difficult to treat, and therapists should have some knowledge, training, and supervision in dealing with these behaviors.

Special considerations

Personality Disorders. If personality disorders are present it is important to set realistic expectations for treatment based on the client's ability to manage these personality traits. Some clients have the ability to make changes to their internal attitudes, values, and beliefs and also change their external behavior. Others only make changes to appease external demands and have difficulty making internal changes. These two concepts represent points on a continuum and most clients fall somewhere in the middle. However, setting up unrealistic expectations is a recipe for therapeutic failure for both the therapist and the client. Consider the client who has been diagnosed with anti-social personality disorder (not just demonstrating features of this disorder). This individual most likely will make changes to appease authority figures and only respond well to external controls that are placed around his or her behavior. Setting goals that require a significant amount of insight and internal change will not be realistic or helpful to this type of client. The treatment areas previously listed are crucial to address for individuals with any form of compulsive behavior. The following are some specific considerations for those with sexually compulsive behavior:

Medications. As mentioned previously, many clients are not able to manage their sexually compulsive behaviors, depression, and/or anxiety without medications. To not refer a client for a medication evaluation is often a set-up for treatment failure.

Length of Treatment. The length of treatment for sexually compulsive behavior is typically 24-to-36 months. During that time it is critical that the therapist help develop a strong support network for the client that may include family, friends, support groups, or other social activities. Following termination, it also may be important to schedule quarterly individual maintenance sessions to

ensure that healthy recovery strategies are being utilized.

The case of Mark

Mark is 38 years old and married. He and his wife sought counseling based on her concern of Mark's frequent masturbation and use of pornography. His wife, Ann, has reported that over the past several years Mark has become less sexual with her and that he admits to masturbating an average of twice per day. Mark has spent an undetermined amount of money on his pornography "collection." Mark did not dispute any information and he reported he has made several attempts to stop his masturbation and pornography use, but has been unsuccessful. Ann feels her emotional relationship with Mark has decreased significantly and that his relationship with their two children has been declining over the past two years. Ann has issued an ultimatum to Mark ... his behavior must change in order for her to remain in the marriage.

The in-depth assessment begins with a comprehensive interview with Mark to gather information regarding relevant historical data and Mark's sexual history. An initial screening interview with Mark, coupled with the Sexual Addiction Screening Test (SAST), revealed that Mark and Ann's concerns were founded. Mark scored at a level that indicated problematic sexual behavior on the SAST. Based on this information, Ann was referred to her own individual therapist who specialized in working with partners of sexual compulsives.

A more thorough assessment was conducted with Mark including an MMPI-2 to determine any underlying psychological issues that must be addressed such as depression and anxiety. These results were followed up with a Beck Depression Inventory and the Beck Anxiety Inventory to confirm the presence of depression and anxiety and to establish a baseline prior to the onset of therapy. Given the level of anxiety and depression, Mark was given a suicide risk assessment. He was determined to be a low-level risk for suicide at this time. No other personality disorders were identified. An examination of past and present behaviors was conducted to screen for other compulsive or addictive behavior.

The assessment continued by screening Mark for cybersex use (by using the Internet Sex Screening Test), and sexual offense behaviors. Mark's detailed sexual history interview revealed that he has experienced fantasies of exposing himself to women in public places, but reports that he has not acted on these fantasies. Mark's legal history did not indicate any sexual crimes, including exhibitionism. Based on this assessment, the following treatment plan was developed for Mark.

Short Term (first three months):

- * Refer to primary care physician for a complete physical examination as

well as an assessment.

- * Refer to psychiatrist for medication evaluation to address depression, anxiety, and compulsive sexual behavior.
- * Refer to group therapy that would focus on sexually compulsive behaviors.
- * Introduce psycho-education modules on cycle awareness as well as relapse prevention.
- * Help Mark develop cognitive-behavioral strategies to minimize the compulsive sexual behavior (e.g., not carrying large amounts of cash for purchasing pornography or going to stores where he has bought pornography, use thought-stopping techniques, identify and change rituals around sexual behavior).
- * Refer Mark to local support group for sexual compulsivity.
- * Secure a sponsor or one other trusted individual (other than partner) to which to confide and use for support.
- * Implement and construct a 90-day celibacy contract.
- * Assist Mark in developing a sexual health recovery plan.

Long Term (after three months)

- * Explore grief and loss issues regarding giving up the behavior.
- * Explore family of origin and past trauma issues, if present.
- * Explore issues such as intimacy and attachment.
- * Implement victim empathy training as a strategy to prevent offense behavior.
- * Explore spirituality issues.
- * Refer for couples work (often, with a separate couples therapist).

Summary of case

At first Mark was overwhelmed and resentful with the number and types of changes he needed to make in his life. It was not until he began to see the positive results of some of the simple changes that he realized he could manage. Although Mark was challenged at times during his first three months, he was able to have more good days than bad. This is often the goal in the initial treatment phase. It is important not to expect perfection and understand that relapse is part of the change process (Prochaska et al., 1995).

As part of Mark's sexual health recovery plan, he and his wife agreed to a 90-day celibacy contract from all forms of sexual contact (including masturbation and pornography). The celibacy contract is one way to jump-start therapy and help clients understand the depth of their difficulties. It also helps break through any denial that remains. Mark experienced several lapses during this abstinence process. He was asked to record any relapses along with the thoughts, feelings, fantasies, and behaviors that he experienced throughout the day of the relapse.

In this context, the relapses were reframed in therapy as helpful events ("prolapses") to determine any triggers that might be contributing to using sex compulsively. Limiting the behavior to only several occasions helped bring out any problematic thinking that was contributing to Mark's compulsive sexual behavior.

Mark also became involved in a 12-step group as a form of support for continuing his newfound sexual health behaviors. He secured a sponsor whom he could trust to be open and honest about helping him improve his sexual health, relationships, and overall quality of life. Notably, Mark's use of pornography and compulsive masturbation began to decrease as he learned to utilize his support network and continued in treatment. All went well until his fourth month of treatment when he experienced a major relapse. Again, the relapse was reframed into a learning experience and strategies were explored to prevent further behavioral binges.

He remained in treatment for approximately 24 months. During that time he attended weekly group sessions and individual sessions on a bi-weekly basis. At the completion of his primary treatment, he continued with periodic individual sessions. During this time a number of issues were addressed including relationship and intimacy issues, past traumas (none were identifiable for Mark), spiritual issues, stress-reduction, and victim empathy training. Overall his progress was positive, with some rough spots along the way. Mark grieved the loss of his behavior throughout therapy and continued to struggle with the fact that he could not use sex as a coping strategy in the future. After his 90-day celibacy contract was over, Mark's sexual health plan allowed for occasional masturbation when not using it to medicate feelings of depression or anxiety. He continued to log his masturbation activity, including his thoughts, feelings, and fantasies before, during, and after the behavior. Mark and his partner entered into couples therapy with a separate therapist who specialized in marriage and family issues. He continued to modify his sexual health recovery plan as new issues arose in treatment and other issues became less problematic.

The bottom line

Similar to other addictions, the treatment of compulsive sex is often complex and challenging. Although there is overlap with other addiction assessment and treatment issues, counselors must employ specific interventions for the sexually compulsive. Whereas this article outlined the problem and possible solutions, it is important for therapists to participate in continuing education, reading, training, and supervision that specifically address compulsive sexual behavior. This article prepares the counselor to make the initial interventions, but unless counselors are trained in this area, referrals should be made to those more familiar with the treatment of sexually compulsive behavior.

The case of Mark was one example of how compulsive sexual behavior may be acted-out; however, there are a myriad of ways that this behavior can be exhibited. For example, issues such as the Internet have changed the way our culture thinks about sexuality. We are more accepting of sexually explicit images in advertisements and other media that make it difficult to fully comprehend the daily struggle for those with sexually compulsive behavior. Awareness raising activities will assist counselors in recognizing, evaluating, and intervening with this often-overlooked population. As we continue to learn about compulsive behavior, we may finally develop techniques to help defeat this cunning, baffling, and powerful phenomenon - and our clients will be the victors.

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Resources for Sexual Compulsivity Information