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Recovery from Sexual Compulsivity

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ABSTRACT

Sexual compulsivity is a developmental adaptation to neglect or abuse that leads to cognitive, behavioral, and emotional consequences as well as impairment in capacity for intimacy. Recovery from sexual compulsivity involves integration of various psychotherapy components needed to address underlying trauma, repetition compulsion, developmental roadblocks, compulsive behavioral reenactments, emotion dysregulation, and intimacy disorder. Effective treatment involves trauma work, symptom-specific treatment, and reconstruction of an erotic template or love map that reduces objectification, compulsion, and variance while affording opportunities for corrective emotional experience, skills development, and enhancement of choices for intimacy.

A male client has obsessive sexual thoughts, spending hours looking at pornography on his computer, rather than spending the evening with his partner. Another compulsively seeks oral sex with anonymous men having large penises, but has no romantic attraction to men. A third is aroused by images of children, while a fourth pays prostitutes to demean him through physical abuse before going home to his family. Such complex adaptations signify why it can be difficult to delineate a rational etiology for sexual compulsivity, and why these clients are often unresponsive to cognitive-behavioral techniques such as relapse prevention, arousal reconditioning, social skills and empathy retraining, or exposure-based therapies.

Sexual compulsivity is a developmental adaptation, and an effective psychotherapy treatment plan requires a comprehensive understanding of the contributing factors. In this age of video games and Internet technology, when children can easily access pornography, early hardwiring can set the stage for objectifying self and others (Owens, Behun, Manning, & Reid, 2012; Struthers, 2009). The sexual activity becomes a means to avoid, withdraw, and disconnect from relationships and demands of daily life. As the therapist reviews the child's response to premature sexualization and critical life events such as neglect and abuse, these unique sexual behaviors can be seen as "emerging survival strategies."

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Subsequently, the sexual adaptations are driven by repetition compulsion in which survivors attempt to gain mastery over neglect or abuse by repeating variant sexual outlet (Freud, 1896/1954; Gleiser, 2002; Van der Kolk, 1989). The adaptations are strengthened by powerful rewards associated with sexual outlet and negative reinforcement occurring when aversive thoughts and feelings are reduced. Sexual compulsivity or recurring involvement in sexually compulsive behaviors restricts the range of exploration, especially excluding opportunities for sharing with an intimate partner or exercising choice in sexuality within the context of a meaningful lifestyle. The drivenness of the behavior, restrictiveness in sexual exploration, and exclusion of intimacy with a consenting, age-appropriate partner form the foundation of a change worthy problem, sexual compulsivity.

Recovery from sexual compulsivity involves revisiting and revising the events by which the child avoided feeling and reconstructing the child's conclusions by using affect-based psychotherapies such as gestalt, psychodrama, internal family systems, schema therapy, eye movement desensitization and reprocessing, and other approaches involving immediate experience, emotional access, or body work. Frequently, the adult client also needs to change the way he or she interacts with people, improve the quality of intimate relationships, and create a balanced life.

Sexual compulsivity as intimacy disorder

Sexual compulsivity can be considered an intimacy disorder. While contemporary sexuality can be experienced spontaneously without pair-bonding or long-term attachment to a committed partner, sexual compulsivity is characterized by an inability to share sexuality with a freely chosen intimate partner. In addition, sexuality compulsivity is trauma-driven, produces unwanted and personally shameful consequences, and interferes with choice in other domains of personal and family life. The missing ingredient in sexual compulsivity is capacity for secure attachment. Effective treatment involves creating what Main and Solomon (1995) called "earned secure attachment," that is, the individual has a history of disorganized attachment and becomes more securely attached with treatment. We also believe that the individual must to establish "earned secure attachment with self," which requires self-compassion, self-soothing, self-efficacy, and self-cohesion (Calverely, 1990).

Sexual compulsivity is commonly related to trauma and neglect reenactments and requires so called "trauma work." Horowitz (1986, 1997), having studied adaptation to severe stressors in childhood, suggested that the common "natural" result of severe trauma is repetition, which consists of flashbacks, intrusions, and reenactments until there is completion or resolution. If the stress response cycle is not successfully completed, erroneous schema become ingrained into the working model of self. In psychoanalytic terms, Stoller (1975) observed, that the individual's life is dedicated to repeating the trauma in disguised form to cope with dissonance such as a nurturing parent having chronic affairs or a priest who molesting children.

The client may dissociate, as one part of self believes the mother is “good,” and another believes she is “bad,” resulting in an inability to integrate experience. The two opposite conclusions cannot be consolidated into narrative memory. Thus a “trauma-bond” is established, which can result in unconscious reenactments of “templates of interpersonal relatedness” (Cloitre, Cohen, & Koenen 2006).

The accumulation of developmental adaptations and repeated consequences contributes to creation of an obsessive-compulsive spectrum disorder, amplified by anxiety fueled by difficulties in affect regulation. Herman (1992, p. 38) noted: “Abused children discover they can produce release through emotions becoming dysregulated and the child is unable to find a consistent strategy for establishing comfort and security under stress.” Such individuals become more likely to exhibit self-destructive behavior: These survivors are impaired in their capacity to reflect upon their own feelings and those of others. Compulsive sexual behavior can then become a vehicle whereby abused children regulate their internal state. The individual survives by suppressing affect and then is compulsively driven to act out for release. Emotions like sadness, fear, loneliness, and anxiety are numbed, or avoided through compulsive activity. Tension reduction affords self-soothing, anesthesia from pain and restoration of affective control.

Recovery from sexual compulsivity involves integration of various psychotherapy components needed to address underlying trauma, repetition compulsion, developmental roadblocks, compulsive behavioral reenactments, emotion dysregulation, and intimacy disorder. Often during childhood and adolescence, the individual is withdrawn or disassociated such that they miss critical life experiences such as dating or intimate rehearsal, which becomes more difficult with increasing age and skills deficits (Fisher & Bidell, 1997). In the absence of critical capacities in negotiating the outside world, described by Greenspan (1977) as “structural abilities,” the client may be unable to address expectations of complex day-to-day interactions. Such structural abilities might include managing social interactions, understanding boundaries, enjoying play and exploration, experiencing pleasure, and demonstrating respect and reciprocity in close relationships.

Frequently, there are deficits in metacognitive processing due to developmentally missed opportunities and guidance. Metacognition is the ability to reflect on and make meaning of one’s mental states (e.g., I’m irritable because I didn’t sleep well), or elaborating a theory of the other’s mind (Mommy is irritable because she is fighting with Daddy) (Fonagy & Target, 1997). Similarly, it is necessary to decentralize, understanding suffering is universal rather than being something only self-endured, thereby establishing a sense of mastery, meaning-making, and personal efficacy (Dimaggio, Carcione, Salvatore, Semerari, & Nicolo, 2010).

Thus, recovery needs to be mapped as a daily process requiring discipline, practice, and time to learn more healthy adaptations and reprocess cognitions. It requires a combination of psychotherapy, self-help meetings, sober-coaching and ideally sharing the journey with a healthy partner capable of secure attachments. The client is taught basic Buddhist principles of self-discipline in order to set

“intentions” for change by not avoiding anxiety-inducing exposures, and then to check out conclusions and interpretations of experiences (Epstein, 1995).

Developmental adaptation

Sroufe (1988) followed 240 individuals from birth to adulthood longitudinally and tested them and their families exhaustively each year after recording their attachment patterns using the “strange-situation” paradigm. His results were extraordinary and revolutionized our understanding of the development of psychopathology. Contrary to the trend toward associating psychopathology with genetic influences on the brain, Sroufe focused on postnatal events shaping behavior.

Sroufe (1988) emphasized the developmental antecedents of psychopathology involved in adaptation to disordered caretaking.

Caregiver psychological unavailability, physical abuse, sexual abuse, and serious distortions in the infant-caregiver relationship were strong predictions of adult psychopathology. Emotional problems are developmental outcomes; that is, they derive from a process of successive transactions of the child and the environment. Disturbance is created by the interplay of multiple factors operating over time, and links between antecedent conditions and disturbance are probabilities and nonlinear. The same process that governs continuity and change in normal adaptors, governs the development of disturbance. (p. 275)

A history of childhood abuse was virtually never related to a positive outcome, and frequently led to a fragmented self and disassociation in adulthood. Sroufe (2005) described the process by which dissociative symptoms arise in adults with a history of early attachment disorganization.

In infancy, in the face of confusing or frightening caregivers, these children had been confronted with the irresolvable conflict of striving to flee from the source of fear yet flee to the source of fear—the caregiver. Collapse of strategies, rapid state changes, and other proto-dissociative mechanisms were all that were available to them. Thus, a prototype of psychic collapse or segregating of experience [as a mechanism of escape] was established. (p. 361)

The internal working models or parental states of mind were affected by life trauma and attachment difficulties were perpetuated across generations increasing risk for a myriad of adaptations in childhood, adolescence, and adulthood (Sroufe, Egeland, Carlson, & Collins, 2005).

Numerous longitudinal studies examined the effects of adaptation to disorganized parent-child attachment. Approximately 30% of disorganized infants continued to display atypical development into early childhood (Cicchetti & Barnett, 1991) and 66% of such children developed controlling-punitive or controlling-caretaking adaptations (Moss, Bureau, Cyr, Mongeau, & St. Laurent, 2004). Controlling-punitive behaviors represented attempts by the child to direct caretaking through shaming and hostility, while the controlling-caregiving pattern involved role-reversal in which the child attempted to attend to parental needs

(O'Connor, Bureau, McCartney, & Lyons-Ruth, 2011). As children aged and gained experience through interaction with the environment, their behavioral adaptations enabled them to cope with the helplessness and fear associated with neglect, abuse, or trauma (Dubois-Comptois, Cyr, & Moss, 2011; Lecompte & Moss, 2014).

Young children with disorganized subtypes continued to experience high levels of stress and problems in social adaptation (e.g., prosocial efforts and cooperative play with peers). Controlling-punitive children exhibited increasing externalizing difficulties, including aggression, and controlling-caregiving children manifested more internalizing problems such as anxiety, depression, and withdrawal (Moss, Cyr, & Dubois-Comptois, 2004; O'Connor et al., 2011). As children with disorganized attachment move toward adolescence, their behavioral adaptations were ingrained as psychopathology and intimacy disorder (Lecompte & Moss, 2014; Lecompte, Moss, Cyr, & Pascuzzo, 2014). The adolescents engaged in behavioral adaptations that produced adverse consequences, destructiveness, anxious avoidance, dissociation, and shame. In order to make social interactions more predictable, the youths objectified themselves or others imposing severe limits on the capacity for intimacy in relationships. It is noteworthy that these behavioral adaptations, observed and reported in longitudinal research, are consistent with historically relevant positions in damaged object relations: moving away from or against instead of the desired moving toward (Horney, 1967).

Object relations theory (e.g., Ainsworth, 1969; Gomez, 1997; Horner, 1984; Mahler, 1995) asserts that healthy development of a child or a system is characterized by constancy, coherence, and agency in which differences are tolerated if not celebrated. The child matures to the point where he or she can tolerate good and bad traits and recognize that persons and ideas have benefits and liabilities. Recovery from sexual compulsivity involves incorporating recent findings from developmental psychopathology to improve models and methods for helping those suffering from the clinical realities that bring persons to treatment.

Developmentally oriented psychotherapy for sexual compulsivity

The praxis to understanding compulsive sexual behavior is that there is not a "cause" for a sexual "deviation," rather there are developmental trajectories for the unique symptoms. Critical life events precipitate positive or negative life experiences, thereby increasing or decreasing the resulting degree of disability, and the likelihood of symptom emergence. Adaptation continually unfolds within an ever-changing context, allowing for developmental variance or for amelioration as an ontogenetic process. Sexually compulsive behaviors can result from different developmental pathways.

Individuals beginning on similar paths may diverge, manifesting different symptoms of deviation. A statement such as the most common contributing factor to pedophilia is a history of sexual abuse, seems reasonable based on research data,

but can also be misleading, since most individuals molested do not develop pedophilic sexual arousal. Any simplistic “cause seeking” model needs to be discarded to understand how certain critical events in a person’s development can become pernicious enough to cause divergence in sexual unfolding. For paraphilias, the specific expression of sexual arousal has a biographical basis (Schwartz & Masters, 1984). For example, persons aroused by auto-erotic asphyxiation may have certain critical events in their trajectory in common, such as molestation with a pillow over their face. Identifying such critical developmental events is crucial to the therapy process in our model of treatment. A corollary of this is that understanding non-deviant sexual arousal that is typically culturally established is quite likely equally complex. The current prevalent use of the Internet and social media by adolescents likely has a significant influence on this process, especially with certain subtypes of adolescents, and more than likely greatly amplifies the risk of objectification of self and others (Owens, Behun, Manning, & Reid, 2012).

We use narrative-based therapies to help clients establish a cohesive-coherent narrative of their life events. We involve family members and friends in this process, and use expressive therapies to access unsuppressed or suppressed affect related to unintegrated memories, such as a sibling being favored or a child being unwanted at birth. The unsuppressed affect can result in cognitive-affective distortions which become eroticized. For example, unsuppressed affect can activate an adolescent male’s desire for attractive girls who are mean and rejecting, then activate prior resentment of early rejection from the mother. The rage can somehow be transposed into forced sex imagery as the brain struggles with contradictory emotions of moving toward and away from someone they need and fear.

Many clients have enormous difficulty knowing what they are feeling and instead are flooded with anxiety. If they experience the onset of a negative emotion, it becomes intolerable and they impulsively move into sexual activity to avoid and escape. Working with affect tolerance (Neacsiu, Rizvi, & Linehan, 2010) followed by exposures to emotions without acting on them is then practiced daily.

Attachment issues

Secure attachment in intimate relationships refers to the capacity to turn to caretakers for a secure base, feelings of safety and security, and the experience of being seen and known as valued (Bowlby, 1969, 1973, 1980). Establishing, maintaining, and recovering attachment are essential to survival and adaptation (Harlow & Harlow, 1962; 1963; 1965). Secure attachment provides a means of effective affect regulation. The secure base allows children freedom to explore their environment and interact with others, establishing a core sense of self and identity, as well as self-efficacy and mastery (Main, Kaplan, & Cassidy, 1985).

When there is a lack of attunement with the caretaker, abuse, or neglect, the child sometimes role-reverses and inhibits the expression of neediness (insecure avoidant style), while other children may amplify their expression of neediness,

activating the attachment system in an effort to capture the mother's unpredictable attention (insecure preoccupied style). By over-focusing on the unreliable caretaker, the child fails to explore his or her environment and develop self-agency, self-awareness, and self-cohesion. The resulting anxiety, as they get older without core skills, can be expressed as a hypersexual fantasy. In one scenario, the individual maintains loyalty to the caretaker by becoming a compulsive caretaker (codependent), at the cost of the developing self (Lyons-Ruth, 1993). Then, they use pornography as a "safe" way to allow sexuality without anticipated rejection or abandonment—and without threat to the primary bond.

Sroufe (1988) found that insecure avoidant boys were likely to bully, lie, cheat, destroy things, brag, act cruelly, disrupt the class, swear, tease, threaten, argue, and throw temper tantrums. On the other hand, insecure avoidant girls became depressed and blamed themselves. This quite likely is the source of increased aggression in males sexually acting-out, in contrast to females. As avoidant children reach adolescence (Gillath & Schachner, 2006), they tend to engage in sex, to feel similar to their peers, but claim it is not enjoyable or they feel very little. This suggests they may require the additional stimulation of illicitness to feel even minimal arousal since their bodies are numb or less responsive to touch and affection. Being held and touched is necessary for children to establish somatosensory responsivity. For this reason, hypersexual individuals in recovery almost always become hyposexual if they find a partner and unresponsive to their partners in sex. Sensate focus, pioneered by Masters and Johnson (1970), and mindfulness exercises are critical to increase responsivity.

The intimacy disorder therefore originates in the child feeling unloved and unsafe, thus fearing closeness with others. Later, it becomes too difficult to rehearse sexual activities with self or with a romantic partner, so distance is created by masturbating to pornographic or paraphiliac images. Objectifying the other's body seems to provide enough reactive distance to get affection without activating the pain of rejection or enmeshment. In Money's terms (1986), the love-map or template for self and others becomes objectified, such that sexual arousal diverts from the natural trajectory and is blocked, allowing the unusual or bizarre to intrude or displace (paraphilia). The behavior can create an addictive cycle as it becomes a functional means of self-soothing and modulating intense emotions. The individual responds to stress by escaping into fantasy, or copes with distress by numbing and escaping into an "illusion of intimacy." The problem is that the connection is temporary and quickly followed by emptiness, requiring more sexual activity to escape feeling even worse.

Even individuals with enough social capital to marry or date often describe feelings of emptiness and loneliness. Like a hormone unable to bind to a receptor site, other people are available, but clients cannot connect with them to assuage their inner emptiness. This emptiness seems to be related to the absence of a core sense of an integrated self. They verbalize that they feel like an impostor, filled with self-hatred and shame. They remain internally in a state of self-conflict with polarized

parts of self continually in battle. They achieve, but remain perfectionistically driven to do more. They can sometimes find partners, but become quickly bored or engaged in conflict, successfully pushing them away. Their hypersexual behavior may be temporarily suspended by a new encounter, but once the early stage of exploration and discovery declines, they cannot bond.

We therefore believe that it is necessary in treatment for clients to form a compassionate relationship with the neglected and injured parts of self, disowned in childhood, and make reparations. Cognitive therapies are used to stop negative self-statements (Epstein, 1997). As described earlier, we teach daily mindfulness to re-associate the body sensations, and to recognize and tolerate emotional states using dialectical behavior therapy (Linehan, 1993). If there is PTSD or complex trauma, we seek resolution with cognitive reprocessing therapies to develop a cohesive sense of self. Often destructive prior relationships need to be terminated and family work is essential to repair damaging destructive cycles and establish healthy boundaries. Choosing a partner with secure attachment is critical, so clients are taught to recognize characteristics of avoidant, preoccupied, and disorganized partners.

To repair the attachment system, a person's internal working model requires a "template" that often does not exist when there is severe neglect. Brown and Elliot (2016) developed a technique to remap attachment representations using the Ideal Parent. They ask the client to imagine a different set of parents, ideally suited to their nature. They then support the client's recognition of parents who are present, reliable, consistent, and interested in the child, facilitating the child's growth through safety and exploration. The technique is often astounding to clients as they recognize the degree of absence they originally experienced. When resistance emerges, it is useful in working with aspects of minimization, denial, and loyalty to the family system. A love map with clearer expectations of self and other is "written-in," practiced, and then further differentiated in rehearsals with the therapeutic community, friendships, and dating. [Table 1](#) lists components of Ideal Parent work.

Trauma and dissociation

When a child encounters sexualization prematurely, it is, as novelist John Fowles says, like "a ship sent out to sea without a rudder." Thus, a loving father having chronic affairs or a nurturing mother who is highly seductive and brings different

Table 1. Characteristics of the ideal parent.

Physical Presence
Consistency
Reliability
Interest
Protection
Attunement (behavior, internal state development)
Soothing and Reassurance
Express Delight
Encouragement for Exploration
Outer Exploration

men home to sleep, leaves the child with contradictions that are difficult to integrate, particularly if the brain is not fully mature. The result is internal splits, i.e., good mom does bad things, because she is driven by her “bad sexuality,” dissociative templates then are engrained into the child’s developing sense of self (Putnam, 1997; Schwartz, 1998). Hendrix (2007) in his IMAGO therapy suggests that positive and negative attributes of caretakers are involved in mate selection. One solution to dealing with unintegrated parts of self might be, for example, to find a wife who is like the Madonna, but the husband can experience sexual arousal only in affairs with the “temptress” on dating sites. Conceptualizing parts with polarized templates lends itself to gestalt-like interventions.

A critical component of trauma is implicit in Freud’s writing on repetition-compulsion. Freud (1896/1954) observed, “the patient remembers nothing of what is” forgotten, but he expresses it in action in an attempt to achieve mastery over the traumatic situation. Reenactments may be understood as arising from templates set in place through affective behavior. Cloitre and colleagues (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2009) indicated, “templates of interpersonal relatedness” are formed on the basis of past experiences with others and guide future behavior. Thus, if the priest comes to dinner and then molests the child in the child’s own bedroom while the parents are in the living room, the experience may be impossible to integrate because of the dramatic contradictions. The memories may then become unavailable for long-term memory, but are enacted first in doll play or drawings of sexual activity, on sexual websites, then by sexual acting-out. These repetitions result in dissociation; one part of self acts out while another part of self has rigid integrity. We use cognitive-reprocessing therapy (Resnick, Monson, & Chard, 2016), Internal Family Systems therapy (Schwartz, 1995), and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001), and exposure based treatments (Foa, Rothbaum, Riggs, & Murdock, 1991) all with the same client to get to very different material in the cognitive reprocessing.

The obvious treatment consists of first establishing control over the out-of-control behavior, followed by increasing ability to remember experience emotions of past trauma, and narrate the emerging story. This is done with one foot in the past and one in the present to allow the adult self to correct cognitive distortions and provide internal safety and reassurance. Unconscious repetitions are then made explicit with behavioral suggestions to write about the destructive past enactments. Attempts by survivors to gain mastery over past traumatic experiences bridge from attachment difficulties, through trauma, toward compulsive reenactments. Thus, effective treatment must target attachment adaptations, trauma symptoms, and compulsive behaviors. The treatment model for sexual compulsivity extends to the basic origins of psychotherapy.

Freud (1896/1954; 1905/1962) found that psychic trauma resulted from premature or over-excitation of a vulnerable nervous system, through betrayal perpetrated by an adult or caretaker charged with the responsibility of protecting the child from harm. Thus, Freud’s view of trauma indicated a disruption of normal

development and disruption of capacity for relationships with others. Sexual addiction as intimacy dysfunction is closely related to distrust of others, avoidance of nutritious life experiences and preference for non-partner-oriented sexuality over time. Freud (1914/1958; 1920/1954) also described the efforts of the person to resolve the developmental trauma through the repetition compulsion, by which the forgotten memories and contexts are replayed actually or symbolically in an attempt to gain mastery over the experience of neglect, abuse, or trauma. The contemporary Internet culture of sexual compulsivity favors virtual and non-relational sex through ease of access, affordability, and anonymity (Cooper, Putnam, Panchon, & Boies, 1999; Young, 2008). Sexual fantasies and obsessions function as yearning for trauma resolution and substitutes for intimate relationships (Leedes, 2001).

Money (1986) described “love maps,” formed in the course of development through omission, displacement, and other errors that interfered with opportunities to engage in partner-oriented sexual intimacy (Money & Lamacz, 1989). Schwartz and Southern (1999) discussed problems of attachment, especially sexual compulsivity, as manifestations of damaged development of affectional systems. Surviving lack of attachment, neglect, or abuse early in childhood contributes to problems of affect regulation and increasing dependence upon compulsive behaviors to cope with overwhelming interpersonal experiences. Ongoing problems with attachment impair self-development and disrupt the capacity for intimacy, resulting in a lack of empathy for oneself or others and distorted love maps (Money, 1986).

Obsessive-compulsive spectrum disorder

Another component of the treatment model is the obsessive-compulsive (OCD) spectrum dimension of sexual enactment. In some cases of paraphilia, prescribing a drug such as Nardil or Anafranil (monoamine oxidase inhibitor and tricyclic) will quickly bring the behavior under control. This suggests that in some individuals, brain changes are involved in the anxiety driven, compulsive nature of deviant sexual arousal. When events in childhood seem chaotic and out of control, and the caregivers cannot be trusted to provide comfort or safety, some children cope by developing repetitive patterns such as checking that the door is locked or washing their hands. The fear is channeled into an illusion of safety by distracting oneself with repetitive acts. The brain seems to adapt to these efforts to manage anxiety, and the individual avoids and protects the vulnerable self by establishing an illusion of control. It seems reasonable to assume that for some individuals, sexual fantasy, pornography, or paraphilia would become eroticized compulsive rituals.

Assuming there is an OCD component to some sexual deviations, the treatment of choice is exposure therapy with response prevention (Whittal, Thordarson, & McLean, 2005). This entails the repeated enacting of the ritual so that: (a) the arousal no longer creates release or relief, (b) the behavior is not under the client's

control, and (c) the client is unable to use the arousal to escape stress or reduce anxiety. Fantasy satiation and covert sensitization derived from Cautela's (1967) work modify the functions of compulsive behaviors, revealing underlying mechanisms. The sense of control and illicitness is thereby extinguished. We encourage the patient to develop more insight and become more aware of the cognitive process. We teach the client to identify daily stressors and deal with them directly through problem solving. Meanwhile, we encourage the development of non-deviant arousal and fantasy, and regular rehearsals.

For those engaged in chronic affairs or hook-ups, we ask the client to identify alternatives that can be used early in the cycle to deal with the urge to relapse. Recovery from sexual compulsivity frequently involves attendance at self-help meetings and contacting sponsors and peers for maintaining self-soothing. We also do a great deal of work around developing empathy for self and other so that instead of that person being an "object," the desired individual becomes a person resembling their "friends" in group. Given the severity of early abuse and deprivation, there will need to be ongoing monitoring and coaching for effective life skills.

Life skills development

Once the individual has established control over out-of-control urges and behavior, it is imperative that they begin to turn to people for comfort. Often they need support with social and dating anxiety and coaching regarding boundaries and how to receive affection. [Table 2](#) lists subcategories of coaching that are addressed in the intake and early intervention process.

Table 2. Life skills assessment.

Constructive Thinking
Independent Living
Friendship
Parenting/Inner Child Bonding
Self-Care/Health and Wellness
Time Management
Physical & Emotional Intimacy
Goal Setting
Social
Hobbies and Interests
Money Management
Transitional
Personal Hygiene
Job Keeping
Decision Making
Emotional Awareness
Job Seeking
Problem Solving
Organizational
Attention and Concentration
Technology

Note. The life skills are listed in descending order of importance based on recent clinical experience.

The blueprint of how we live as adults is written by how we were loved as children. If we didn't have maternal nurturing, we may not have the structural capacity to give it. If love consisted of caring for others, we might search out partners requiring caretaking.

We have noticed wide differences in our assessment of skill deficits, idiosyncratic to the individual. Typically, clients don't know what they don't know. Their thinking and behavior suggest structural deficits in self-regulation, relating, affect communication, representing and differentiating experience, and representing internal experiences of self-observation. Using life coaching to practice new behaviors can help to assess such deficits, practice new behaviors and not avoid anxiety-producing solutions. Since clients don't know what they don't know, watching their behavior in social situations can uncover some circumstances that provoke childlike responses to adult situations, and other circumstances in which excessive dependency is followed by conflict or avoidance with people. Mindful self-observation and modeling by the life coach is ameliorative.

Metacognition

Denial, rationalization, and minimization are core criteria for diagnosis of addictive behavior. Individuals deny, minimize, and distort their life narrative, maintaining loyalty to their family system and idealizing people who repeatedly injure them. Add to this their amnesia of traumatic events and inability to accurately remember the early life experiences, developmentally based psychotherapy would seem impossible. Trauma-based psychotherapies are premised on the idea that all memory is potentially inaccurate, since the experiences are selectively filtered through a child's central nervous system, not yet fully differentiated, and then selectively recalled. We have nevertheless found that facilitating a coherent, cohesive narrative of one's perceived development is critical for constructing a coherent sense of self.

Interviewing family members and friends can be extremely helpful. As Kohut (1971) emphasized, each interaction with others provides a potential mirror for self-development. Being aware of cognitive processing of external feedback is critical. Fonagy, Gergeley, Jurist, and Target (2002) have written extensively on meta-communication "thinking about thinking." Distinct skills contribute to meta-cognitive capacity, such as the ability to reflect on and make meaning of one's mental states or elaborate a theory of the other's mind and decentralize, thereby making sense of others and contextualizing accurately. Shame, self-hatred, and the inability to empathize with self or others results in the erroneous coding of feedback. The individual can have inflexible self-focused attention, perseverative thinking styles in the form of rumination related to the past or future, or attentional styles of threat monitoring and coping patterns based on erroneous beliefs (Wells, 2005). The individual believes he or she must worry in response to negative thoughts in order to be prepared. By paying attention to every perceived

danger, harm can be avoided. Positive thoughts might tempt fate and being too good will surely be followed by something bad.

With this in mind, the sexually compulsive individual commonly perceives the world through various lenses, which lead to a “confirmatory bias” in which novel experiences are avoided, potential refutation is not processed, and self-defeating errors in thinking must persist. Typical clusters of distorted views in sexual compulsivity are listed in [Table 3](#).

With such filters, every interaction with others can result in anxiety relieved only by acting out. Monitoring cognitive distortions and altering conversations with self is thus critical to recovery and establishing a core sense of self. This requires a daily commitment to uncovering and challenging each self-statement.

Brown and Elliot (2016) reviewed extensive literature related to metacognition. The core features include:

- (a) mental state of self (i.e., “I am defective”);
- (b) mental state of others (i.e., “Nobody could care for someone such as me”);
- (c) developmental aspects of mental states (i.e., “Because girls rejected me in high school, no-one will ever desire me”);
- (d) decentralization (i.e., “I am the only person with this affliction”);
- (e) mastery (i.e., “there is nothing I can do to have a desirable partner”); and
- (f) relation with therapist (i.e., “if they knew the truth they would despise me”).

Ultimately psychotherapy targeted toward the disorganized attachment style and focused on assessing and then altering such thinking is critical to moving toward “earned secure attachment.” We use a specialized group for metacognitive reprocessing with weekly “homework” assignments to change patterns of thinking. We find large variance within group members in our assessments of meta-cognitive deficits, so individualized assignments are critical.

Table 3. Distorted view in sexual compulsivity.

-
- I am an imposter
 - If people knew that I lack integrity, they would not respect me
 - Therefore, I must not allow myself to get close enough for others to see me
 - I am defective
 - I am not like other people
 - I must present an image to others that they like
 - I must not disappoint other people
 - I am a pervert
 - I will be despised for my affliction
 - I was born broken
 - It is unfair and since life is unfair to me, I am not responsible for hurting others
 - My behavior is not my choice
 - I cannot stop it
 - No one can understand
 - I am not like others
 - I must keep it a secret
 - I can pretend to change but the only relief is death
 - I cannot reveal the truth
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Discussion

Sexual compulsivity is more about intimacy, attachment, and connection with self and others, and less about sex. Desire and arousal emerge developmentally from optimal caring, compassion, and competent parenting attuned to the unique temperament of the child. The attachment system can become deactivated when a person feels engulfed, and activated when a person perceives abandonment. Therefore, recovery is a process that encourages repair of the attachment system. For individuals with sexually compulsive behavior, however, hypersexuality is used to both activate and deactivate attachment, mirroring their early history of disorganized attachment. It is imperative to work with cognition, affect, and behavior to facilitate internal integration and seed an interrelated cohesive sense of self before facilitating closeness with others that might activate trauma bonds and fears.

Additionally, the ability to experience and articulate emotions as a signal for constructive action is a requirement for secure attachment. Assessing one's past with "fresh" adult wisdom and gaining perspective in relation to intergenerational and cultural influences are critical. Making meaning and working through losses and grief can allow for greater ability to be present and experience life in the moment. Mapping recovery as creating the capacity for secure attachment allows clients to delineate the steps necessary to abstain from compulsive behavior while creating a life capable of experiencing both joy and pain.

After developing a cohesive written narrative that is also presented in group, we examine family loyalties, idealizations, and extremes of contemptuousness. We assess the childlike capacity to play and feel joy, and degrees of self-hatred, perfectionism, and punitiveness. Issues of loss and grieving are related to the capacity to feel affection. Finally the attunement of the client with the therapist, values toward connection, and the ability to look at oneself flexibly, are all part of metacognitive capacities. These components, taken together, form the core of facilitating earned secure attachment with self and others in the process of recovery from sexual compulsivity.

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