

Comprehensive Treatment of Sexually Compulsive Behavior

Stephen Southern, Ed.D.

Licensed Clinical Psychologist (IL) & Certified Sex Therapist
(AASECT)

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Objectives

1. Identify common characteristics of compulsive sexual behavior across various models
2. Describe current treatment approaches
3. Discuss how advancement of sexual health contributes to prevention and treatment of problematic sexual behavior.

Description

Sexual addiction as a construct has enjoyed a robust journey over more than 30 years of theory, practice and research. The disorder has enjoyed support among adherents of especially an addiction model of intervention, while detractors challenge the diagnosis as reflecting biased conventional social construction. The acceptance of gambling disorder as a behavioral addiction and the proliferation of pornography use via technology inform the identification of problematic sexual behavior. Ultimately, advancement of sexual health resolves controversies and cultivates a new view.

Shame by Any Name

- A teenage boy who loses interest in school, friends, and dating consumed by Internet porn
- A college girl who loses herself and her dignity after disappearing in the BDSM scene and being traded as a sex slave
- A Sunday School teacher who is exposed in the news after being arrested for masturbating in open view in the living room of her apartment
- A seminary student who risks health and harm from driven sexual encounters at “bareback” parties
- An allied health worker who loses his job from repeatedly looking at porn at work
- A doctor who is referred to an impaired physician’s program after taking indecent liberties in physical examinations
- A newlywed whose new life is disrupted when he is arrested for voyeurism
- A secretary who loses her job by meeting partners on Tinder during the workday
- An isolative science student who injures his body by compulsively masturbating while inserting objects in his rectum
- A curious man who is beaten and robbed when he compulsively seeks anonymous partners contacted on the Internet
- A man who spends hours at a mall escalator trying to “upskirt” video teenage girls
- A woman who has sexual relations with partners she meets in bars nearly every night
- A college man who cannot achieve an erection in partner-oriented sex with his fiancée because his arousal template has been affected by repetitive, increasingly aggressive porn he views online each night
- A man pressures his partner into swinging then they develop relationship conflict and anxiety

Addiction Defined

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pursuing reward and/or relief by substance use and other behaviors...Addiction affects neurotransmission and interaction between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol, and other drugs) leads to a biological and behavioral response to external cues, in turn triggering craving and/or engagement in addictive behaviors (American Society of Addiction Medicine, 2011)

What Is Not Sexual Addiction

- Differentiate non-consensual sexual behavior from out-of-control sexual behavior (Vigorito & Braun-Harvey, 2018, p. 416)
- Treatment should not oppress sexual minorities (Birchard, 2018a, p. 450)
- Assessment and treatment for sexual addiction should not pathologize diverse sexual behaviors (Halpern, 2011; Winters, 2010)
- Sexual addiction should not be used as excuse or cover for immoral, unacceptable or illegal behavior (Carpenter & Krueger, 2013; Moser, 2011)
- Porn and sex addiction could be used by addiction treatment industry to justify unnecessary and iatrogenic treatment (Ley, 2018)

AASECT Position on Sex Addiction

- Founded in 1967, the American Association of Sexuality Educators, Counselors and Therapists (AASECT) is devoted to the promotion of sexual health by the development and advancement of the fields of sexuality education, counseling and therapy. With this mission, AASECT accepts the responsibility of training, certifying and advancing high standards in the practice of sexuality education services, counseling and therapy. When contentious topics and cultural conflicts impede sexuality education and health care, AASECT may publish position statements to clarify standards to protect consumer sexual health and sexual rights.
- AASECT recognizes that people may experience significant physical, psychological, spiritual and sexual health consequences related to their sexual urges, thoughts or behaviors. AASECT recommends that its members utilize models that do not unduly pathologize consensual sexual behaviors. AASECT 1) does not find sufficient empirical evidence to support the classification of sex addiction or porn addiction as a mental health disorder, and 2) does not find the sexual addiction training and treatment methods and educational pedagogies to be adequately informed by accurate human sexuality knowledge. Therefore, it is the position of AASECT that linking problems related to sexual urges, thoughts or behaviors to a porn/sexual addiction process cannot be advanced by AASECT as a standard of practice for sexuality education delivery, counseling or therapy.
- AASECT advocates for a collaborative movement to establish standards of care supported by science, public health consensus and the rigorous protection of sexual rights for consumers seeking treatment for problems related to consensual sexual urges, thoughts or behaviors. (AASECT, n.d.)

Sexual Addiction as Behavioral Addiction

- Parallels *gambling disorder* which is the only non-substance-related disorder in the DSM-5 (APA, 2013, p.585)
 - Persistent and recurrent problematic behavior leading to clinically significant impairment or distress
 - Not better explained by manic episode

Gambling Disorder

- Four or more of the following in 12-month period:
- Needs to gamble with increasing amounts of money to achieve the desired excitement
- Is restless or irritable when attempting to cut down or stop gambling
- Has made repeated unsuccessful efforts to control, cut back or stop gambling
- Is often preoccupied with gambling
- After losing money gambling, often returns another day to get even (“chasing losses”)
- Lies to conceal extent of involvement with gambling
- Has jeopardized or lost a significant relationship, job, educational or career opportunity because of gambling
- Relies on others to provide money to relieve desperate situations caused by gambling

Internet Gaming Disorder (APA, 2013, p. 795)

- Five or more of the following in 12-month period:
- Preoccupation with Internet games
- Withdrawal symptoms when Internet gaming is taken away
- Tolerance-the need to spend increasing amounts of time engaged in Internet games
- Loss of interest in previous hobbies and entertainment as a result of, and with the exception of, Internet games
- Continued excessive use of Internet games despite knowledge of psychosocial problems
- Has deceived family members, therapists, or others regarding the amount of Internet gaming
- Use of Internet games to escape or relieve a negative mood
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of participation in Internet games

Classic Models

- Three models of sexual addiction early in the field:
- Patrick Carnes (1983) coined the term, *sex addiction* as a disease amenable to 12 Step Treatment
- Masters & Johnson Institute treated *sexual compulsivity* as a form of intimacy dysfunction (Schwartz, Galperin, & Masters, 1995)
- Eli Coleman at the University of Minnesota Medical School explored the condition from the standpoint of co-morbid mental disorders (e.g., anxiety disorders) and health risk (Coleman, 1991)

Emergence of Contemporary Models

- Classic models emphasized the experience of men in problematic sexual behavior
- Contemporary models ushered in by Internet exposure to pornography and sexual contacts among adolescents and women (Ferree, Hudson, Katehakis, McDaniel, & Valenti-Anderson, 2012; Owens, Behun, Manning, & Reid, 2012)
- *Triple A Engine* of Internet /social media: anonymity, accessibility, and affordability (Cooper, Putnam, Planchon, & Boies, 1999)

Contemporary Models

- Three decades of research supports the basic disease concept in sexual addiction (Phillips, Hajela, & Hilton, 2015)
- Biopsychosocial model: impulse control dysfunction in activation of the amygdala, behavioral reward through dopaminergic neurotransmission, inadequacy of cognitive control in prefrontal cortex (Samenow, 2010b, Stein, 2008)
- Kafka (2010) highlighted monoamine transmitters (serotonin, norepinephrine, and dopamine) and testosterone in increased drive and disinhibition of sexual behavior
- Anxiety, depression, and negative affect as co-morbid conditions, possibly consequences of compulsive sexual behavior (Birchard, 2018b)
- Some connection between heightened sexual arousal and internally produced opiates (Samenow, 2010b)
- Emerging neuroscience of attachment (Katehakis, 2009, 2016) may account for sexual addiction/compulsivity

Hypersexual Disorder

- Herring (2004) described his participation in consensus groups to have sexual addiction included in the DSM
- Kafka (2010) proposed *Hypersexual Disorder* as a unifying construct that could be included in the DSM-5
- Samenow (2011, pp. 109-110) noted that hypersexual disorder is non-specific, possibly confounded by co-morbid conditions, and lacks clear causation and medical evidence at present

Hypersexual Disorder

- At least 4 of the following 5 criteria (Kafka, 2013, p. 21):
- A.1 sexual preoccupation or excessive time invested in thought, planning, or engaging in the behavior);
- A.2 using sex to cope with negative mood states;
- A.3 repetitively using fantasies urges and behavior in response to stressful life events;
- A.4 trying to reduce or control the sexual behaviors without success; and
- A.5 continuing to engage in the repetitive sexual behaviors in spite of significant physical or emotional harm to oneself or others.

Compulsive Sexual Behaviour Disorder

The World Health Organization recently adopted criteria for inclusion of diagnoses in the ICD-11. The Board of the Society for the Advancement of Sexual Health (SASH), endorsed the definition proposed for the ICD-11 (beta draft).

Compulsive Sexual Behaviour Disorder in ICD11

Compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour. Symptoms may include repetitive sexual activities becoming a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities; numerous unsuccessful efforts to significantly reduce repetitive sexual behaviour; and continued repetitive sexual behaviour despite adverse consequences or deriving little or no satisfaction from it.

The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g., 6 months or more), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement.

Problematic Sexual Behaviors

- The Society for the Advancement of Sexual Health (SASH), which sponsors the *Sexual Addiction & Compulsivity* journal, offered a helpful mission statement with an inclusive definition of problematic sexual behaviors.
- The Society for the Advancement of Sexual Health (SASH) is a nonprofit organization dedicated to promoting sexual health and addressing the escalating consequences of problematic sexual behaviors affecting individuals, families and communities. Seeking collaboration among clinical, educational, legal, policy, and research professionals, SASH advocates a multifactorial approach to address problematic sexual behaviors, further research and to promote sexual health in general. (SASH, n.d.)

Framework for Addressing Problematic Sexual Behaviors (Herring, 2017)

- Conflicts with a person's commitments (Are you keeping your promises?)
- Conflicts with a person's values (Are you OK with what you are doing?)
- Conflicts with a person's self-control (Are you in control of yourself?)
- Results in negative consequences (Is everything OK?)
- Lacks fundamental sexual responsibility (Are you protecting others?)

Back to the Future

- Freud (1896/1954; 1905/1962) originally asserted that psychic trauma resulted from premature or over excitation of a vulnerable nervous system through harmful experiences perpetrated by an adult or caretaker charged with the responsibility of protecting and representing the best interests of the child.
- Thus, Freud's view of trauma indicated disruption of normal neurological development and *betrayal* by a powerful other.
- 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.

Back to the Future

- Freud (1920/1954) also described the efforts of the person to resolve the developmental trauma through the *repetition compulsion*, by which the original scene of the crime is recreated actually or symbolically in an attempt to gain mastery over the experience of neglect, abuse, or trauma.
- The contemporary culture of sexual addiction favors virtual and nonrelational sex

Trauma and addiction are two sides of an intergenerational shame transmission process. As survivors enter active trauma reconstruction treatment, characterized by instigative methods to relive and revise neglect, abuse or loss, there are marked increases in urges to escape the distress through addictive behaviors. As addicts maintain abstinence for longer periods of time and move through recovery, underlying trauma, including intrusive recollection and anxiety, increase. In most cases, concurrent treatment of trauma and addiction is required to internalize treatment gains and avoid relapse.

LIFE TRAUMA/ADDICTION TREATMENT: UNTYING THE GORDIAN KNOT

Process Addictions and Addictive Disorders

- Addictions Counseling has recognized the prevalence of process addictions or addictive disorders in substance abusing clients (Hagedorn, 2009)
- 17-41 million people present Internet addictions
- 17-37 million present sexual addiction or compulsive sexual behavior
- 14-26 million eating disorders or food addictions
- 6-9 million gambling addiction or pathological gambling
- Other addictive disorders include self injurious behavior, workaholism, and compulsive exercise

Back to the Future

- Robert Stoller (1975) in particular analyzed cases of irresistible sexual behaviors that produced dysfunction in areas of daily life.
- His model of perversion as an “eroticized form of hatred” (Stoller, 1975) accounted for the development and maintenance of paraphilias or variant sexual preferences, which produced personal shame, social judgment, relational conflict, and victimization of oneself or others. Similar to the concept of accumulating consequences in sexually addictive behaviors, paraphilias were viewed as change worthy by virtue of shame, suffering, impairment, and loss of control.
- Paraphilias tended to reflect codes for distortions in psychosexual development and attempts at corrective solutions to childhood trauma (Birchard, 2011).
- John Money (1986) described *love maps*, formed in the course of development through omission, displacement, and other errors that interfered with opportunities to choose partner-oriented sexual intimacy (Money & Lamacz, 1989).
- Sexual fantasies and obsessions function as yearning for trauma resolution and substitutes for intimate relationships (Leedes, 2001).

Sexual Attachment

Schwartz and Southern (1999) discussed problems of sexual attachment, especially sexual compulsion, as manifestations of damaged development of affectional systems. Surviving lack of bonding, neglect or abuse early in childhood contributed to problems of affect regulation and increasing dependence upon addictive disorders or processes in order to cope with overwhelming interpersonal experiences. Ongoing problems with attachment impair self-development and disrupt capacity for intimacy resulting in lack of empathy for oneself or others .

Sexual Attachment

Deficits in the development of affectional systems lead to difficulties with self-cohesion, fragmentation of parts of oneself, and avoidance of potentially corrective experiences with safe intimacy. The antidote for splitting involves maintaining of a safe container or “holding environment” (Winnicott, 1961) for disowned parts of self, tolerance of emotional upheaval without relying upon disturbed sexual solutions, graduated exposure to feared intimacy, sustaining of loving kindness and respect in genuine relationships, and engagement of creative and spiritual resources (Southern, 2002).

Recovery from Sexual Compulsivity

- Address underlying trauma
- Disrupt repetition compulsion and reenactments
- Establish secure attachment
- Maintain emotion regulation
- Reconstruct erotic template
- Develop coping, social, and life skills
- Enhance choices for genuine intimacy

Recovery from Sexual Compulsivity

- Experiencing safe attachment to attuned therapist
- Developing emotion regulation, metacognitive/reflective, and coping skills
- Establishing deliberative choice over out-of-control behavior
- Increasing ability to remember and experience emotions of past trauma
- Gaining mastery over re-enactments
- Narrating the emerging story
- Restructuring of cognition and overcoming distortion and bias
- Restoring opportunities for learning life skills
- Sustaining capacity for attachment
- Developing intimacy in a safe relationship
- Experiencing joy and freedom
- Reclaiming rights for healthy sexuality

Shame: Core of Sexual Addiction

Shame is an inner experience of being completely diminished or insufficient as a person. It is self-judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being (Fossum & Masson, 1986, p. 5).

Shame Reduction in Group Therapy and Self-Help

- Shame is reduced by overcoming secrecy, reducing isolation, becoming vulnerable and experiencing unconditional acceptance in group (Griffin-Shelley, 2018)
- Group therapy is important in 12 step facilitation and relapse prevention (Birchard, 2018b)
- Similar to other addictions, recovery based on attending 12 step, self-help groups: Sex Addicts Anonymous, Sexaholics Anonymous, Sex and Love Addicts Anonymous (Stein & Carnes, 2018)

Shame Reduction in Couple and Family Therapy

- Frequently, individuals enter treatment because of consequences of sexual addiction in a marriage, partnership, or family system
- Spouses or partners of sexual addicts experience sense of betrayal and violation, sometimes associated with symptoms of traumatic stress (Collins, 2018)
- Facilitating the disclosure process is another step in shame reduction and healing (Schneider & Corley, 2012)
- Additional care may be indicated for children and other vulnerable family members who may be affected by the sexual addiction

Assessment

- Cyber Pornography Use Inventory
- Hypersexual Behavior Inventory
- Internet Sex Screening Test
- Sexual Addiction Screening Test-Revised
- Grubbs, Hook, Griffin, Penberthy, & Kraus (2018)

Treatment Components

Facilitating Healing

- Strengthening capacity for self-soothing and resiliency
- Environmental structure and safety
- Limit and boundary setting
- Graduated self-disclosure
- Venturing forth through creativity and experiential therapy
- Development of non-addictive coping resources
- Initiation of meaningful recovery program in a sanctuary or culture of care

Implementing Change

- Relapse prevention
- Facilitation of movement through stages of change
- Focal treatment of clinical syndromes and symptom complexes
- Psychoeducation for understanding recovery from trauma and addiction
- Mindfulness approaches and acceptance/commitment
- Establishing a spiritual growth program
- Deepening of the therapeutic alliance

Treatment Components

Reconstructing the Self

- Activating dysfunctional schemata through instigative methods and containing contents that emerge from instigation
- Exposure based therapy procedures
- Facilitating inter-personality communication among ego states and integrating split-off parts of the self
- Deconstructing, processing, and integrating of life trauma in recovery self system
- Active engagement in life history narration and depiction
- Examination of opportunities for intimacy, creativity, and spirituality
- Progression through a spiritual growth program to detoxify emerging shame

Reconstructing Family Systems

- Constructing and processing messages from genograms, family drawings, family sculpture, and related methods
- Addressing unfinished business in families of origin and current family systems
- Couples therapy whenever possible; concurrent individual therapy of partners
- Positive parenting training and coaching
- Family programs of support for ongoing recovery
- Relational contracting to prepare for family re-entry
- Extending recovery to the community and addressing trauma and addiction in social institutions
- Engaging in advocacy, voluntarism, and social justice

Treatment

- Prolonged Exposure (Foa, Rothbaum, Riggs, & Murdock, 1991)
- Cognitive Reprocessing (Resnick, Monson, & Chard, 2016)
- Eye Movement Desensitization and Reprocessing (Shapiro, 2001)
- Internal Family Systems Therapy (Schwartz, 1995)
- Schema Therapy (Young, Klosko, & Weishaar, 2006).
- Seeking Safety (Navavits, 2002)

Pharmacological Treatment

- Various medications indicated to deal with underlying impulsivity, anxiety, or depression (Thibaut, 2018)
- Some treatments directly address sexual desire and acting out behavior, including anti-androgen intervention
- Mood stabilizers and atypical neuroleptics
- Selective serotonin reuptake inhibitors
- Nefazodone (Serzone) and Clomipramine (Anafranil) for obsessions
- Topiramate (Topamax) for multiple behavioral addictions
- Naltrexone for blocking endogenous opioids and triggering of dopaminergic reward system

Treatment

- Mentalization-based Therapy (Bateman & Fonagy, 2012; Berry & Lam, 2018)
- Deliberative Decision Making (Braun-Harvey & Vigorito, 2015)
- Cognitive Behavior Therapy (Birchard, 2018b)
- 30 Task Model (Carnes, 2009)
- Mindfulness Meditation (Chandiramani, 2018)
- Creative Arts Therapy (Wilson, 2018)

Special Populations

- Adolescents
 - Early exposure to Internet pornography
 - Social media
 - Lack of sex education/information
 - Childhood sexual abuse
 - Bullying and social isolation
 - Peer pressure
- Women (Feree et al., 2012)
 - Relational trauma
 - Sexual abuse, harassment, and rape
 - Romance/fantasy preoccupation
 - Relational boundary issues
 - Caretaking and codependence
 - Enmeshment and emotional incest
- Men who have sex with men (Chaney & Burns-Wortham, 2018)
 - Minority stress
 - Internalized heterosexism
 - Sexual venues
 - Substance use
 - Childhood trauma
 - Internet and social media apps
 - MSM-affirmative treatment

Special Populations

- Clergy and religious persons (Thoburn, Seebeck, & Teal, 2018)
 - Religious fundamentalism
 - Sex negative childhood upbringing
 - Blurred boundaries in congregation/fellowship
 - Excessive self and family denial
 - Burden of selfhood in role/context
 - 40 percent of pastors had sexual contact with members
- Professional sexual misconduct (Samenow & Schneider, 2018)
 - Medical and psychiatric impairment
 - Substance use disorder
 - Childhood physical/sexual abuse
 - Wounded healer
 - Inadequate professional education
- Sex offenders (Smith, 2018)
 - Childhood sexual abuse
 - Attachment disorder or personality disorder
 - Variant sexual preference or paraphilia
 - Predatory behavior
 - Opportunity and accessibility to victims

Sexual Health

Sexual health embodies more than the absence of sexual addiction or dysfunction. The construct of sexual health is based on the recognition of an individual's right to self-determination of sexual preferences and practices in the absence of harm to oneself or another person. Sexual health extends beyond functioning to include choices, values, and cultural contexts.

Vision for Sexual Health (SASH)

Sexual health is a label commonly used to describe a state of wellbeing in relation to sexuality across the lifespan. It is often considered to have biological, psychological, sociological, and spiritual dimensions, and is more than merely the absence of a sexual disease or dysfunction. Sexual health involves managing the benefits, risks, and responsibilities of sexual exploration and play, love and intimacy, pleasure and joy, as well as meaning making and spiritual transcendence.

Sexual health promotes the well-being of individuals and relationships and prevents undue adverse consequences to self and others. This means that sexual health involves a balance between sexual rights and sexual responsibilities. Sexually healthy individuals integrate sexuality in a manner that contributes to the well-being of their lives, while avoiding or reducing harmful consequences for themselves and others.

Sexual health is supported by open, honest, and direct communication about sexuality throughout the lifespan. Sexuality itself includes thoughts, fantasies, desires, attitudes, values, behaviors, roles, and relationships. Therefore, a very important way to improve sexual health is to improve sexual communication.

SASH considers sexual health to be positively affected by a person's right to self-determination of sexual expression, gender, orientation, reproduction, lifestyle and relationships. Since these important determinations can be a result of many complex factors, it is important that people have access to sufficient information and resources to support this process.

Finally, communities and even nations can be considered sexually healthy only to the extent that they provide support and resources to educate, support and protect the sexual health of their members. SASH is proud to contribute to the advancement of this important aspect of sexual health.

Definitions of Sexual Health

- Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.
- Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships.
- Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.
- World Health Organization

Life Behaviors of Sexually Health Adults (SIECUS)

- Appreciate one's own body
- Affirms that sexual development may or may not include reproduction or genital sexual experience
- Interact with both genders in respectful and appropriate ways
- Affirm one's own sexual orientation and respect the sexual orientation of others
- Express love and intimacy in appropriate ways
- Develop and maintain meaningful relationships
- Avoid exploitative and manipulative relationships
- Make informed choices about family options and lifestyles
- Exhibit skills that enhance personal relationships
- Discriminate between life enhancing sexual behaviors and those that are harmful to self and/or others
- Express one's sexuality while respecting the sexual rights of others
- Express one's sexuality in ways congruent with one's values

Dimensions of Positive Sexuality

- Spirituality: the core of sexuality; rejecting sexual shame and affirming that sex is good
- Personhood: the development of autonomy; accepting one's sexual self and respecting boundaries
- Roles & relationships: the expression of trust, vulnerability and mutuality
- Behaviors and activities: the initiation of safe and pleasurable sexual activities
- Physical function: the opportunity to experience the full range of human sexual response
- Manley (1999)

Optimal Sexuality

- being present,
- connection,
- intimacy,
- communication,
- exploration/fun,
- authenticity,
- vulnerability/surrender, and
- transcendence/transformation
- Kleinplatz et al. (2009)

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