

# Gender and Addictions: Men and Women in Treatment

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## **Outpatient Treatment for Sexual Dependency with Alcoholic and Drug Addicted Men**

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Men recovering from a history of substance abuse sometimes face the disappointing reality that chemical sobriety is not the end of their problematic sexual behavior. They may find themselves able to abstain from alcohol and drugs, yet continue sexual behavior that is a source of confusion, secrecy, and distress. Addiction treatment professionals may also find their client's sexual behavior a source of consternation and frustration. Therapists may be perplexed about how to continue treatment and may find themselves personally ambivalent about addressing the sexual problems of their client.

This chapter will address the issue of recovering men who are disturbed by their preoccupation with excessive or unacceptable sexual behavior. It will review the theoretical conceptualizations of compulsive sexual behavior, sexual addiction, and hyperphilia/paraphilia and address the interactive influences between substance abuse and sexually dependent behavior among both gay and heterosexual men. Using the models of motivational interviewing (Miller and Rollnick 1991) and the change process (Prochaska and DiClemente, 1982) as a foundation, this chapter will discuss a variety of treatment approaches for men with sexual dependency.

## **Sexual Problems and Men**

Sexual problems such as hyperphilia, compulsive sexual behaviors and sexual addictions are much more prevalent among men than women in treatment (Carnes 1991, Coleman 1992, Money 1984). Various explanations are postulated for this gender difference, including the greater propensity for men to self-identify or be diagnosed with having sexual problems. Gender differences have also been noted in other forms of problematic sexual behavior. Carnes (1991) found that men engage more frequently in excessive behaviors that objectify their partners and

require little emotional involvement, whereas women tend toward excessive behaviors that distort power. Carnes also found that men intensify sexual behavioral trends already existing in the general male population, whereas women with sexual dependency usually break general social conventions about women. According to Coleman (1992) men more commonly suffer from compulsive sexual behavior involving cruising and multiple partners than from multiple sexual relationships involving emotional connections.

Research literature seems to support connections between disturbed and traumatic psychological wounds in early life, failed gender expectations, and sexual addiction, compulsion or hyperphilia in men (Coleman 1990, Earle 1995, Money 1984). For example, the experience of physical or sexual abuse in childhood may force a young male to experience a gender expectation failure (i.e., not being in control, victimization by an aggressor, and being forced into a passive role during sexual contact). This painful experience becomes deeply shameful as the boy learns through socialization that this experience may call his maleness into question.

Some men may develop sexual rituals that allow them secretly to cross their socially presented gender selves and explore alternative means of expression. For example, a heterosexual single man may spend hundreds of dollars a month hiring dominatrix prostitutes, which allows him to cross-traditional male gender conventions without risking public social shame. Acknowledging the stress associated with male gender expectations, and helping the client understand his psychological response in not meeting these mandates, is an important component of treating sexually dependent men.

## **The Historical Conceptualizations of Sexual Dependency**

The cultural and historical relativity of sexual behaviors and the cultural specific definitions of “controlled” and “uncontrolled” sexual behavior have been used to argue against the very notion of sexual deviancy. “What one society regards as being sexually out of control or deviant may or may not be viewed as such in another” (Levine and Troiden, 1988, page 351). Currently, the United States has three normative, yet competing “erotic codes.” Sexual behavior can be *procreational*, *relational* and/or *recreational*. This means that for some, sexual pleasure can be valued only when limited to the context of procreation within a heterosexual marriage. For others, sexual contact can also be a means of expressing and reinforcing one’s emotional and psychological intimacy within any committed relationship. Still others view erotic feelings and sexual expressions between mutually consenting adults, even between strangers, without emotional commitment as acceptable behavior. These conflicting views create an underlying tension in the conceptualization and treatment of sexual dependency, and are reflected in the many historical labels used to describe excessive sexual behavior among men such as: the Casanova type, compulsive promiscuity, compulsive sexuality, Don Juanism or the Don Juan syndrome/ complex, erotomania, hyperaesthesia, hypereroticism, hyperlibido, hypersensuality, hypersexuality, idiopathic sexual precocity, oversexuality, pansexual promiscuity, pathologic multipartnerism, pathologic promiscuity, satyriasis, sexual hyperversion and urethromania (Orford, 1978).

## **Current Conceptualizations for Out of Control Sexual Behavior**

The key diagnostic terms currently used to label excessive sexual behavior are: compulsive sexual behavior, sexual addiction and hyperphilia. None of these three contemporary terms is currently used in the DSM-IV as a recognized diagnostic category and no

consensus exists whether excessive sexual behavior can be described as an addictive disorder, impulsive behavior, obsessive-compulsive behavior or a psycho-sexual disorder. Some attempts were made to include a category of a psychosexual disorder called “Hyperactive Sexual Desire Disorder” in DSM III, however, these attempts were abandoned (Coleman, 1986). The terms reviewed in this chapter are associated with the original researchers who have written extensively to promote their particular theory.

### **Compulsive Sexual Behavior**

The idea of compulsive sexual behavior has been most widely researched by Eli Coleman, Ph.D. He defines compulsive sexual behavior as a behavior driven by anxiety reduction mechanisms rather than by sexual desire. The obsessive sexual thoughts and compulsive behaviors serve the function of temporarily reducing anxiety and distress. However, these same thoughts and behaviors create a self-perpetuating cycle, since the temporary relief that they provide is followed by further psychological distress (Coleman, 1990).

Coleman sees compulsive sexual behavior as a symptom of a more pervasive obsessive-compulsive disorder (OCD), in which the “anxiety driven behavior happens to be sexual in nature” (Coleman 1990, page 12). Some experts believe compulsive sexual behavior does not meet the diagnostic criteria for OCD because sexual behavior involves pleasurable behavior and feelings. According to Coleman, persons with compulsive sexual behavior “rarely report pleasure in their obsessions or compulsive behavior . . . their recurrent thoughts or behaviors are senseless or distasteful”(Coleman 1990, page 12).

The married man who insists upon sexual intercourse with his wife several times a day exemplifies compulsive sexual behavior. Varying the type of sexual contact, such as mutual

masturbation, oral sex or simply masturbating himself is simply unacceptable. He needs the specific ritual or “fix” to avoid feeling depressed, nervous or irritated. Another example could be a gay man in a committed relationship who spends hours “cruising” gay chat lines on computer bulletin boards. He may spend all day looking for opportunities to hook up with a sex partner or engage in phone sex and then rush to complete home or work duties that will cover up the evidence of this compulsive ritual. The anxiety and stress of this cover-up plus living on the edge of discovery may lead to further compulsive sexual episodes.

### **Sexual Addiction**

In the 1970s the term “addiction” began to be more loosely applied to destructive forms of sexual behavior. This may have started because the lack of behavioral control associated with men’s sexual behavior resembled the behavior of alcohol and drug addicts (Carnes 1990, Coleman 1990). In 1983 Patrick Carnes published *The Sexual Addiction*, which resulted in the popularization and recognition by some clinicians and researchers that sexual addiction is a clinically identifiable illness. Carnes provides an operational definition of **sexual addiction** as “a pathological relationship with a mood-altering experience” (Carnes 1989, page 4-5). “The sex addict relies on sex for comfort from pain, nurturing, or relief from stress, etc., the way an alcoholic relies on alcohol, or a drug addict on drugs” (Carnes 1989, page 4-5). The sexual addiction becomes the primary driving force in the addict’s life. Persons suffering from sexual addiction are called sex addicts in much the same way a person suffering with alcoholism is called an alcoholic. According to Carnes, a sex addict “transforms sex into the primary relationship or need, for which all else may be sacrificed, including family, friends, values,

health, safety, and work” (Carnes 1989, page 5).

Sexual addiction differs from sexual compulsion in that in sexual compulsion the sexual behavior is a means to reduce anxiety inherent in an underlying obsessive-compulsive disorder. In sexual addiction, sexual behavior is out of control and is relied upon for coping, nurturing, or stress relief that transforms sex into the central organizing principle of one’s life. With compulsive sexual behavior, the sexual behavior is a serious symptom of an untreated disorder, whereas in sexual addiction the sexual behavior is the problem.

Sexual addiction may escalate resulting in a progressive decline in psychological functioning for some addicts, while others may remain constant in their behavior over many years. For example, a single bisexual man spends his rent and food money on prostitutes, phone sex and pornography. He promises himself he will not let this happen again, only to find himself in more debt for the same behavior three months later. A gay recovering crystal methamphetamine addict may have anonymous sex five to ten times a week, sometimes with crystal using partners, risking his drug recovery to maintain his sexual addiction. Other sex addicts may substitute one addictive behavior for another. For example, an alcoholic may have been arrested for anonymous public restroom sex while drinking and, as a result, in sobriety may engage in calling 976 phone lines to talk with other men while masturbating himself.

The sex addict has developed a system of faulty beliefs, impaired thinking, and a repetitive addictive cycle that can be influenced by family, culture and other addictions. For example he may hold the belief that his sex drive is just more intense than other’s, or if people were not so hung up on sex and just loosened up there would not be a problem. The addict views the concern of others about his sexual behavior as a symptom of their problem, not his. He may

also view each sexual activity as a separate experience and not look at the larger pattern of behavior. He will promise himself he will not go back to a particular video book store or nude beach, but not connect this promise with the ten previous times he has made similar bargains with himself.

This addictive system repeats itself through a series of phases: initiation, establishment, contingent-escalation, contingent-deescalation, acute and chronic (Carnes 1989). The first two phases describe the beginning of an addiction with the remaining phases addressing the growth process of a sexual addiction. In the contingent-escalation phase the addictive system is fully established and fluctuates in intensity depending upon certain environmental or emotional events. Most sexual addicts progress to the acute phase in which a break with reality occurs and the preoccupation with sexual thoughts and behavior is almost constant. At this point either the addict gets help or proceeds to the chronic phase. In this phase, according to Carnes, the addiction is irreversible and no longer responsive to treatment. The only way to stop the behavior is to limit opportunities through institutionalization.

These phases can occur within a variety of sexual behaviors. Carnes categorizes all sexual addiction into three levels of addictive behavior. These three levels of acuity depend on the actual behavior and its consequences within the culture, under the law, for other persons and in public opinion. (Carnes, 1989) Level one behavior includes behavior that is usually considered acceptable within the culture and is widely practiced. Masturbation, same/opposite gender sexual relationships, pornography, computer chat line activity and prostitution are examples of level one behavior. Nuisance behavior is the common factor in level two behavior. Exhibitionism, voyeurism, bestiality, indecent phone calls and indecent liberties are not



considered acceptable, judged as sick behaviors and may involve serious legal consequences. Level three always involves dangerous and victimizing sexual behavior. Incest, child molestation, rape, and other forms of coercion and forced sexual contact are involved at this level.

### **Paraphilia and Hyperphilia**

An alternative model proposed by John Money, Ph.D. involves neither an obsessive-compulsive nor an addictive disorder conceptualization. Money has investigated human sexuality and developed a vocabulary for discussing what are typically called sexual perversions or kinky and bizarre behavior. Today, these unconventional erotic fantasies and sexual behaviors are known as paraphilias. Money has defined more than 50 paraphilias or unconventional sexual behaviors that an individual may require to achieve a state of erotic arousal or to achieve orgasm (Money 1988). Some more common paraphilias are defined in DSM-IV. Common paraphilias include: exhibitionism, voyeurism, fetishism, pedophilia and frotteurism (sexual arousal contingent upon rubbing the genital area against the body of a stranger in a densely packed crowd).

Sexual behaviors that are in conformity with standards dictated by customary, religious, or legal authorities are normophilic (Money 1988). An excessively dominant, prevalent or frequent normophilic sexual behavior is called hyperphilia. Hyperphilia, as postulated by Money, is a pathology in which lust displaces love and lovebonding. This displacement results in the genitalia functioning in the service of lust, typically with multiple partners and with compulsive frequency (Money, 1986). "The hyperphilic solution is one in which the lovemap

defies defacement, so that the sex organs, in adulthood, are used with exaggerated defiance, frequency, and compulsiveness, and/or with great multiplicity of partners, in pairs or in groups” (Money 1984, page 165). Lovemap, a term originated by Money, is an individual’s specific template depicting his idealized lover and idealized romantic and erotic relationship with the lover. It includes a person’s erotic fantasies and behaviors. Defaced lovemaps, which result from interference with normal childhood sexual rehearsal and development, lead to distortions in sexual fantasies and practices and are responsible for the more than 50 different paraphilias defined by Money (Money 1986). One consequence of a defaced or incomplete lovemap is hyperphilia (Money, 1984).

Money proposes that some men with sexual dependency may be dealing with a paraphilic addiction. “In the language of common sense, an addiction always has a predicate: one is addicted to something . . . The sexual addict is always addicted to something sexually specific.” (Money 1988, page 261). The paraphilic sexual addiction is to something or someone specifically in the context of sexual arousal. Therefore, the person does not have an addiction to sex itself. (Money, 1988) Because the addiction is to a specific sexual object or experience, not sex, Money concludes there is no such entity as sexual addiction (Money 1988).

Coleman makes distinctions between paraphilic and nonparaphilic compulsive sexual behavior (Coleman 1992). When the sexual behavior used in a compulsive way to relieve anxiety is paraphilic, Coleman labels this paraphilic CSB (compulsive sexual behavior). Normative sexual behavior taken to a compulsive extreme is considered nonparaphilic CSB (Coleman 1992). Money has described a certain overlap between paraphilia and hyperphilia. He believes that the existence of paraphilic imagery and ideation may be masked by the hyperphiliac

behavior. For example compulsive cruising and picking up of casual sex partners may be part of a person's paraphilia for having oral sex with the biggest penises. Money also states, "It is not necessary to equate all hyperphilia with paraphilia" (Money 1988, page 176). While diagnostically important, not much research or detailed clinical studies of hyperphilia have been conducted. Hyperphilia is partially addressed in the behavioral symptoms of sexual addiction concerning frequency, loss of control and increasing preoccupation with sexual thoughts and acts. Paraphilia is partially addressed in the model of level one, two and three behaviors discussed earlier. Together, these three conceptualizations can create a useful and potent clinical treatment approach to treat an individual with out of control sexual behavior.

## **Sexual Dependency**

The term Sexual Dependency is a general term to describe sexual behaviors that involve problems of sexual control and excessive, intrusive sexual preoccupation leading to psychological distress. It is assumed that any sexual behavior can become a source of harmful dependence, rather than just certain sexual preferences or object choices. The term sexual dependency will be used throughout this chapter to describe problematic sexual behaviors, while ideas such as compulsive sexual behavior, sexual addiction and hyperphilia will be used only in their specific theoretical orientations. All three conceptualizations see sexual dependency as a ritualistic, repetitive, rigid set of behaviors that require professional treatment and compassionate understanding from well-informed clinicians.

## **Etiology, Sexual Orientation and Sexual Dependency**

Much has been researched and postulated about the etiology of sexual dependency (Carnes 1989, Coleman 1986, Money 1986). Researchers agree that childhood trauma, an

abusive and restrictive family milieu, and sociological and cultural influences contribute to a predisposition for sexual dependency. Some have also hypothesized genetic, neurological and/or biochemical explanations for this problem (Coleman, Cesnik, Moore & Dwyer, 1992). Others have studied mood disorders in nonparaphilic male sex addicts (Kafka, 1991).

The inability of a person with compulsive sexual behavior to control behavior may be found in “abnormalities in the basal ganglia and/or the prefrontal cortex of the brain” (Coleman, 1990). It is believed the compulsive sexual behavior is in part explained by neurotransmitter dysfunction that can be treated with serotonergic medications. Psychotherapy with pharmacotherapy is an essential treatment plan. “Through psychotherapy a person can resolve the sources of psychiatric problems and psychosexual disorder, learn better ways of managing anxiety, and healthy ways of expressing sexuality and meeting intimacy needs”(Coleman 1992, page 324).

Carnes examined the childhood family systems of adult sexual addicts using the circumplex model of marital and family systems (Carnes, 1989). The circumplex model describes several possible extremes a family can reach in its functioning plus providing a means and a vocabulary for examining adaptability and cohesion in family dynamics. Carnes views adaptability and cohesion dynamics as crucial to understanding the family system of a sex addict.

Straight and Gay sex addicts intensify already existing trends in male heterosexual and homosexual sexual behavior. Rarely will a gay male sex addict become preoccupied with the opposite sex. While heterosexually identified sexually dependent men may report experiencing same sex contact, they are usually involved in this activity due to circumstances in which males are more readily available than female partners.

Gay men must deal with the added oppression that the very act of their lovemaking is illegal in some states, let alone considered perverse, deviant, sinful and sick by many. Consequently, gay men with sexual dependency walk an additional tightrope in defining their own sexual health in a culture that relegates their entire sexual self to the margins of society. A sexually dependent gay man who is in the developmental stages of coming out may face additional stressors in his diagnosis and recovery from sexual dependency. For example, a thirty-three-year-old single devout Mormon requests an assessment for sexual compulsion because he goes to pornographic bookstores to watch videos and receive oral sex from anonymous men. He is trying to honor the church's expectation of no premarital sex but of course is sinning even more deeply by being sexual with men. An extensive understanding of the forces of homophobia, religion, sexual orientation and sexual dependency is required to understand this man's behavior and to establish appropriate treatment goals.

### **Substance Abuse and Sexual Dependency**

Research and clinical experience supports the likelihood of a higher incidence of sexual dependency among substance abusing men (Coleman, 1987). The issue of undeveloped or dysfunctional sexuality has long been a significant focus of treatment and recovery. Yet only recently has the addiction treatment community been distinguishing between sexual dysfunction secondary to alcohol and drug abuse and sexual dependency that requires separate treatment from substance abuse treatment.

Sadly, the professional addiction treatment community does not have a reputation for effectively addressing sexuality issues. The spread of HIV and other sexually transmitted diseases has required chemical dependency counselors to confront these limitations. However,

understanding issues surrounding sexually transmitted diseases does not constitute sufficient knowledge and training for therapists treating substance-abusing men with sexual dependency problems. Specific emphasis on sexual dependency assessment and treatment is a necessary part of a multi-disciplinary treatment plan to address the unique clinical needs of a dually diagnosed substance abusing and sexually dependent man.

The reasons for the strong correlation between substance abuse and sexual dependency are manifold. Many chemically dependent adults have rarely, if ever, been sexual without being under the influence of chemicals. The use of chemicals as a disinhibitor to begin exploring sexuality is a commonplace practice for American youth, and drugs are commonly thought of as a reliable resource for managing sexual response. Stimulants such as cocaine and methamphetamine have long been associated with intensifying sexual thoughts, feelings and fantasies (Hoffman, Mayo, Koman, and Caudill, 1994). Some cocaine users only use the drug in sexual situations while others may pursue or engage in sexual activity due to the heightened arousal. One study found that sixty percent of clients entering an outpatient cocaine treatment program describe a pattern of sexual compulsivity (Hoffman et al, 1994). Carnes has noted how alcoholism can interact with sexual addiction in a mutually supportive way (Carnes, 1989). The alcoholic may rationalize his sexual behavior because of having drunk too much. Men who may be anxious about having sex may use a drink or another drug to help themselves relax or worry less about getting an erection or having an orgasm either too fast or not at all (Coleman, 1987).

## **Treatment Issues**

Many recovering addicts and their therapists are surprised to find that chemical sobriety does not result in stopping out-of-control sexual behavior. Equally distressing can be the high

risk for a chemical use relapse when alcohol or other drugs are needed to continue the untreated sexual dependency cycle. A therapist's assessment skills and intervention methods are very important in helping clients maintain chemical sobriety while looking at the possibility of sexual dependency.

The theoretical and personal beliefs of the therapist can be a significant barrier for the client concerned about his sexual behavior. Prematurely using diagnostic language such as "sexual addiction" or "sexual compulsion" can send a client fleeing from treatment. Just as worrisome, these labels can send someone into yet another full program of addiction recovery before an adequate assessment and understanding of the sexual problem is completed. The premature referral to one of the various 12-step programs (Sex Addicts Anonymous, Sex and Love Addicts Anonymous, Sexaholics Anonymous or Sexual Compulsives Anonymous) may be motivated by the therapist's anxiety or discomfort with detailed discussion of a client's sexual world or lack of information and experience in treating sexual dependency. An added complication in such referrals is that these fellowships go by different names, are not unified nationally and do not operate quite the same even if the group's have the same name in the same city.

### **Models for Treatment**

A variety of treatment approaches have been proposed and carried out for the treatment of sexual compulsive disorders, sexual addiction and hyperphilia. Treatment approaches are closely linked to the specific theoretical conceptualization. Men who suffer from compulsive sexual behavior are helped through a combination of psychotherapy and pharmacotherapy (Coleman, 1992). For paraphilia and hyperphilia the ideal treatment is one in which hormonal

and talk therapies are combined (Money, 1986). Sexual addiction is treated through a combination of 12-step programs and psychotherapy (Carnes, 1989). Missing from the literature are studies that address factors that motivate a sexually dependent man to seek and remain in treatment (Garland and Dougher, 1991). While motivation is widely recognized as a key issue in the treatment of sex offenders, studies specific to motivation and sexual dependency are nonexistent. A model for treatment of sexual dependency that focuses on motivating the client toward change and helps the therapist to process the cyclical nature of change with his or her client will be the focus of the remainder of this chapter.

### **The Change Model**

James Prochaska and Carlo DiClemente developed a model for change based on six stages through which people pass to change their problems (Prochaska and DiClemente, 1982). From precontemplation, contemplation and determination to action, maintenance and relapse, these six stages describe the progression of change. A person's readiness for change or motivation to change is stage dependent. People must sometimes experience a cyclical repeating of these stages before establishing a pattern of lasting change. A "wheel of change" which reflects the practice and repetitive nature of changing human behavior represent these stages. It also incorporates relapses as a normal occurrence in change. Because of the universal human desire for sexual relating and the lifetime sexual history clients bring to the counseling room, a model that incorporates slips and relapses as normal, expected occurrences is essential for maintaining motivation for change.

This model requires clinicians to use different approaches and skills with each client depending upon where he is in the change process. When using motivational interviewing



techniques in a professional therapy setting, it is the therapist's responsibility to use stage appropriate counseling strategies to motivate the client to the next stage of change.

A therapist committed to motivating the client toward sexual health will provide a conceptualization that motivates the client at a specific stage of change to move to the next level of change. For example, a heterosexual male with a three-year recovery from cocaine addiction comes to therapy with his wife. The husband masturbates in front of her every morning before work. The husband sees nothing wrong with his masturbation and accuses the wife of being uptight about sex. Although he is willing to attend the therapy session, it is important for the therapist to approach the husband in the context of the precontemplative stage for change. Treatment interactions that raise the husband's doubts about his current behavior and that increase his perception of the risks and problems associated with his current behavior will be more valuable than focusing on diagnosis for sexual dependency. In another example, a recovering alcoholic will consider treating a sexual problem only if his treatment includes an assessment for sexual addiction. It is very important for the therapist to provide the assessment or refer the client to someone who can meet this need.

Prochaska and DiClemente's change model is useful when treating sexually dependent behavior. Each phase from the precontemplative to the relapse stage is the backdrop for considering timely clinical treatment strategies that build on the premise of client and therapist mutually negotiating for change. Traditional clinical addiction treatment protocols emphasize teaching the recovering addict how to change, using a skill building approach, i.e., "Do this now," "Do not do that yet." These protocols underemphasize how the therapist, by actively creating discomfort within the client, enhances motivation for change and resolves the client's

painful personal ambivalence. The emotional and cognitive process of resolving ambivalence empowers the client to experience his own intrinsic motivation for change. Thus the principle for treatment is to have change arise from within rather than be imposed from without. Treatment sessions ideally will have the client, rather than the therapist, presenting arguments for change.

The development of the notion of motivational interviewing is based on the work of Miller and Rollnick (1991). They draw upon strategies from client-centered counseling, cognitive therapy, systems theory, and the social psychology of persuasion to design an approach that helps “clients build commitment and reach a decision to change.” While most therapists working in the field of addiction are armed with a treasure chest full of actions that client’s may take to change their behavior, taking action is the fourth stage in the change model. Presenting action-oriented options when a client is still contemplating whether he is sexually dependent will not lead to increased motivation for change. It will also not help the client resolve the underlying central issue in front of him, namely, his ambivalence.

### **Precontemplation: Getting to ambivalence**

Men with sexual compulsion, addiction or hyperphilia may appear for treatment at this stage in response to a recent arrest, a threat of separation or divorce from their spouse or a workplace related disciplinary action. In other words, the motivation for being in the therapist’s office is due to the motivation and needs of someone other than the client. The community wants him to stop breaking the law and victimizing citizens, or the family or employer can no longer tolerate the behavior. The treatment goal is to move the client to the contemplative stage. Raising the client’s doubts about his sexual behavior and increasing his reality-based perceptions

regarding the risks and problems with his current behavior will accomplish this move towards contemplation. In other words, the therapist fosters the client's ambivalence about his sexual behavior. Primarily, the goal is to have the client understand in a more conscious way his internal conflict. The client is "caught in an approach-avoidance conflict" (Miller and Rollnick, 1991, page 40) in which he needs to become increasingly aware of the costs and benefits of his unique individual situation.

Effective strategies are those that help the client see his ambivalence and articulate reasons for change. If the client revealed over the phone that he had a recent arrest or personal crisis, the therapist may ask: "You told me on the phone that you had recently been arrested; will you fill me in on what happened?" or "What concerns have you had that you decided to give me a call?" These very elementary beginnings can convey that the therapist is interested in understanding the client's perception of his life, not the perception of the source of his motivation.

Listening reflectively is the distinct art of conveying a response that attempts to summarize what the client said. The reflective part invites the client to either clarify or confirm the therapist's assumption. This skill is especially important for working with sexually dependent clients who feel shame and defensiveness about their sexual behavior and anxiety when talking to a total stranger about sex. As sexually active as many sexually dependent men are, they can be extremely uncomfortable in speaking honestly to anyone about sex.

When the court orders a client to schedule an appointment, the therapist can praise the client for making the call, being on time and speaking openly. For another client, affirming reactions from the therapist about the client's difficulty in revealing this part of himself and

having finally accomplished taking a step toward honest self-disclosure can be an important reinforcer.

Summarizing the clinical session at intervals throughout the initial sessions as well at the end of each session can be very useful for sexual dependents. If the client is sexually compulsive and managing an untreated anxiety disorder, the summation can act as an organizing and calming experience for the client. It provides time to put several ideas together, since his anxiety may be interrupting his ability to reflect and review. For the sexual addict, a summation is a means of interrupting or slowing down an impulsive spilling of his psychological internal self. Without time for summation, the client may become so focused and dissociated during the session that he may leave the office in a mental blackout not unlike that experienced after a sexual binge. Summarizing can also be an effective tool to address a possible hyperphilia. The verbal review can begin externalizing the distorted perceptions that accompany the client's lovemap. The summary may be the first time the client has heard or experienced his lovemap from somewhere other than his own thoughts.

A crucial strategy in motivational interviewing, according to Miller and Rollnick (1991), is to elicit from the client "self motivational statements." The goal is to have the sexually dependent client verbally express his own recognition of the problem and voice concern about his sexual behavior. He might state a direct desire to change his sexual behavior. He may also express some optimism and ability to make a change (self-efficacy) in his sexual behavior. It is essential that these statements are made in response to the client deliberating about his own ambivalent thoughts, not in response to a confrontation or a convincing argument the therapist may have offered. Self motivational statements lie at the heart of motivational interviewing.

Miller and Rollnick review several strategies for eliciting self motivational statements. These strategies include a variety of questions that invite the client to look more closely at himself without being burdened with judgements, conclusions or decisions. Examples of these strategies include: What else do you do that concerns you? What else are you tired of not being able to stop? What do you like about your sexual behavior? What would you miss the most if you were to change your sexual behavior? The strategy here is to acknowledge the loss and the gain resulting from changing one's behavior. This is particularly important when dealing with the powerful feelings and sensations associated with sexual contact. Reviewing the positives of his behavior can also provide a window into the future challenges the client may face in maintaining his motivation for continued recovery.

Questions that invite the client to discuss the worst or most painful aspect of his behavior are also useful in altering motivation. For example, "What is the most frightening sexual situation you have ever been in?" or "What are you most worried about will happen to you?" The therapist must not expect that the client will focus on the same issues that might most concern the therapist. It is very important for the therapist to know what worries the client the most, because that is the source of potential motivation for change in future stages.

If a therapist engages in a premature debate with clients, it will result in defensiveness from the client. Sometimes this is what a therapist calls denial or client resistance. Rarely does a therapist conclude after an intense exchange with a client that the conflict is a direct result of the therapist using a clinical skill that does not match with the client's current motivational level. Nevertheless, this is in fact what often happens.

Asking the client to reflect on larger issues beyond his sexual behavior will allow both

client and therapist to meet the part of the client who has aspirations, ideals and values that he holds dear. This information will be valuable in pointing out the discrepancy between the sexual behavior and these higher ideals. The trick is not to get prematurely focused on these contradictions. Allowing the client to express these ideals can help motivate him to contemplate his sexual behavior in more detail. Exploring these contradictions will be done at a later motivational stage.

The clinical circumstance of the initial contact is another factor that influences the pre-contemplative stage. Inpatient hospital programs specifically designed for sexual compulsive or addictive behaviors are rare. In an acute setting such as a hospital or intensive outpatient chemical dependency treatment setting, establishing the patient's motivation for being in a time-limited acute treatment setting is very important. "There is a tendency to think that when time is limited (as it generally is), you just have to confront people and tell them what to do. The problem, however, is that people's reaction to such strategies tend to be the same, whether or not time is limited" (Miller and Rollnick 1991, page 133). The stages and phases for motivating change must still be experienced by the patient and worked through. The time to accomplish this work, however, may be compressed.

### **Contemplation: Tolerating Ambivalence**

When the client is simultaneously considering and rejecting change, he has moved from precontemplation to contemplation. Contemplation may be the stage in which a person suffering with sexual dependency most frequently presents for treatment. For many clients, the therapy room is the only safe place to discuss their ambivalence about change. A spouse, friend or even fellow 12-step group member may quickly engage in a debate rather than listening to the internal

conflict that may be surfacing. The pervasive ignorance in the general population regarding sexual dependence plus the lack of nonjudgmental resources to discuss “perversions” makes the confidentiality of the therapy room an important resource. The most common mistake therapists make when meeting with a client at this stage is prematurely focusing on client actions. By focusing on resolving the client’s ambivalence, the therapist moves the client closer to being ready for change and teaches him the most important skill he will need after any future relapses. The client begins to tolerate diverse feelings and motives, learning to evaluate these internal conflicts without remaining in the relapse state. To move beyond the discouragement or demoralization following a relapse, clients need to become very skilled at observing ambivalence and be empowered to process the ambivalence. Taking this step allows the client to move on to determining a plan of action to get back on his feet. Normalizing ambivalence as a necessary part of the change process provides the client one of the most powerful sources of hope he will need throughout his treatment for compulsive sexual behavior, sexual addiction or hyperphilia.

A structured assessment process is an essential resource for the client to resolve ambivalence. Before beginning an assessment process, the client should verbalize to the therapist what he hopes to gain from the assessment. Male sexual dependents who identify as gay in orientation or consistently complete their sexual ritual primarily with male partners may be looking for a diagnosis of sexual dependency to confirm their own homophobic beliefs about their orientation. They may think their desires for men are sick and view treatment for sexual dependency as a way to end their homosexual desire or behavior. The client’s goals and plans for using the assessment information provide insight into how he feels about his overall sexuality.

During the assessment process the clinician is faced with sorting out the disparate theoretical conceptualizations discussed earlier. Typically, assessment should include “a complete clinical history and psychosocial history, a thorough sexual history, objective and projective personality testing, sexual behavior inventories and, a family interview if possible” (Harnell 1995, page 91). For adults in treatment for sexual related offenses, a clinical polygraph examination and a penile plethysmography may be mandated (Earle, 1995). A physical exam by a urologist will explore any internal or external damage to the genitalia. Personality inventories and other mood disorder evaluation measures can be of assistance. Assessing the interaction between sexual behavior and dependency on drugs, alcohol, gambling, and/or eating disorders is essential to revealing the coping function of the anxiety avoidant or compulsive addictive sexual behavior. Determining the extent of the patterned sexual behavior plus the individual’s ideal sexual scenario is extremely important in the assessment process (Carnes, 1989). Carnes has developed the Sexual Addiction Screening Test (SAST) and more recently the Gay Sexual Addiction Screening Test [G-SAST] (The Carnes Update, Spring 1995). Given the recent success of pharmacological therapies, a psychiatric assessment for potential use of lithium carbonate, fluoxetine and other psychotropic medications is recommended (Coleman, 1992; Kafka, 1991). An assessment of the client’s motivation is another important component of a comprehensive assessment (Miller and Rollnick, 1991). This can be addressed by having the client create a decisional balance sheet that summarizes the perceived positive versus negative effects of the client’s sexual behavior (Miller and Rollnick, 1991).

Successfully navigating the normal resistances presented by ambivalent clients is essential to moving clients into the determination stage. Motivational interviewing suggests



several strategies for dealing with resistance. They include reflection, shifting focus, emphasizing personal choice and control, reframing, and therapeutic paradoxes. No matter what form of resistance a client presents, from arguing or interrupting to denying or ignoring, these motivational techniques interrupt a verbal dance that the client has been repeating either in his mind or in his relationships. For example, a client may report he hired a prostitute the day after his last therapy appointment. Reframing the behavior by asking him what needs was he trying to meet through this behavior rather than letting the client focus on judgements or disappointments can increase contemplation regarding the behavior and increase the probability for a more determined course of action.

### **Determination: Toward Action**

Recognizing when a sexually dependent man is ready for change is an important and sometimes difficult clinical skill. Important clues may include his complete cooperation with the assessment process and a genuine interest in the information and what personal relevance it may have for himself. Timely arrival for appointments and maintaining focus on goals without the need for therapist-imposed limits is another clue that the client may be more determined to prepare for change. A general lessening of the urgency and anguish may occur when the client no longer verbalizes impatience regarding the recovery process or uses the therapy hour for constant reassurance. The client may initiate discussion of self observations regarding his sexual behavior or thoughts that previously went undetected or were kept to himself. The client may have begun to experiment with initiating his own ideas for addressing his problem.

Setting limits on clients who are too eager to “get going” on their recovery is important.

For some clients seeking approval or getting a spouse or partner “off their back” may motivate this rush into sexual health. For others it may be a response to feelings of anxiety or another symptom of an impulsive style. It is important that the treatment plan be a joint effort planned in a clearly articulated procedure that allows the client to ask questions and to understand why the therapist is recommending certain courses of action.

Another area crucial to maintaining client motivation is the actual assessment review and treatment recommendation meeting. It is recommended that therapists do not discuss any behavior changes during the assessment phase unless the client and the therapist see the behavior as having grave consequences for himself or another person. Because behaviors such as exhibitionism, voyeurism, and sexual assault always have a victim, specific behavioral contracts or consideration of inpatient treatment may be required as part of the initial assessment. The specific details of what these boundaries may entail should be clearly reviewed with the client in the initial session.

To help with establishing a course for treatment, the client should write a personal sex plan. A sex plan is a written document that specifies which behaviors the client determines are no longer acceptable and those that may be high risk activities. High risk behaviors may make a sexually dependent man vulnerable to engaging in unacceptable sexual behavior. The plan also outlines the treatment and recovery activities he will pursue in support of his sexual recovery. This list may include individual and group therapy and telephoning other recovering men for support when thinking about engaging in unacceptable behavior. Daily ritual self-care like getting enough sleep, daily meditations, honesty with others and reading inspirational books are other examples of recovery sex plan activities. The clinician must remind the client that these

are only initial objectives and that abstinent behaviors will change as he learns more about his recovery.

Certain 12 step recovery programs define abstinence for its members. Sexaholics Anonymous (SA) is one such program. SA defines sobriety for the married sexaholic as having no form of sex with self or with persons other than the spouse (Sexaholics Anonymous, 1989). For the unmarried sexaholic, sexual sobriety means freedom from sex of any kind, i.e., abstinence. For single and married alike, sexual sobriety also includes “progressive victory over lust” (Sexaholics Anonymous, 1989). The anonymous authors of the publication Hope and Recovery (CompCare, 1987) found that “compulsive abstinence from sex was just as unnatural to us as compulsive sexual behavior had been . . . [and] that behaviors such as having a sexual relationship with someone of the same sex, or having sex before marriage is not necessarily acting-out behavior.” They state that “whatever it is that motivates us to masturbate, not the act of masturbation itself, determines whether the activity should be considered acting-out behavior” (Hope and Recovery 1987, page 77). Coleman states “Treatment of compulsive sexual behavior does not involve eradicating all sexual behavior. Sexual expression is an important ingredient of sexual health. Patients need to set limits or boundaries around certain patterns of sexual expression” (Coleman 1992, p. 324-325).

To increase the frequency of self-motivational behavior, defining acceptable and attainable goals that increase the client’s determination toward recovery is important. If a client wants to end all sexual activity outside heterosexual marriage, then establishing a sex plan that reflects this behavior will be likely to result in increased motivation of the client. If the therapist is concerned that the client’s initial definition of sexual recovery may be unattainable, then the

therapist can ask the client to anticipate the consequences of these possibly unreasonable objectives. When the client expresses the positives and negatives of achieving these initial abstinence goals, it may help him clarify a more reasonable starting place to define his abstinent boundaries.

The high risk aspect of a sex plan contains a list of behaviors plus thoughts, obsessions or preoccupations that put the recovering person at risk for crossing his abstinence line. From a compulsive sexual perspective, this occurs when anxiety triggers illicit rehearsal behaviors that prepare the sexual compulsive to slip into a relapse incident. Example's include driving by the adult bookstore when an alternative route is available, keeping phone numbers for past sexual one night stands, and keeping the phone connected to 900 number services. For others, high risk may be failing to comply with prescription medication treatment recommendations or changing dosage or frequency without first consulting the prescribing physician. High risk mental activities on this list include dissociative states which are frequently experienced during sexual arousal, intense preoccupation with seeing most people as potential sex partners or as sex objects or imagining erotic sexual contact with strangers met throughout the day. The more specific the written description of the thoughts or behavior, the more helpful the sex plan will be to the client.

The recovery list reviews the actions that the client will take to maintain his abstinence goals and begin the healing process. This is the area of treatment that seems to have the most agreement within the various theoretical conceptualizations. It is also the area where using self-motivational principles has significant benefits. With current treatment options for sexual dependency creating hope for recovery, presenting clients with a variety of recovery activities to

choose from may increase his motivation. The primary task for the therapist is to help the client match treatment approaches with treatment goals.

Several factors must be taken into consideration when planning the recovery activities. First, a starting place must be identified. Overwhelming the client with too many treatment modalities and psychological issues is an error. Secondly, some combination of professional psychotherapy with self help measures will need to be explored for each client. Also, a combination of individual, group and family-based treatment modalities is generally seen as a necessary triad for resolution of sexual dependence.

Coleman recommends focusing on family-of-origin issues via individual, group and family therapy. "Intensive treatment is best accomplished in a group therapy format with adjunctive family or relationship therapy. The spouses or partners should also be involved in the treatment process given that they are often similarly afflicted or need assistance because of the damaging effects of the patient's compulsive sexual behavior on the relationship" (Coleman 1992, p. 324).

Given the vast array and availability of options for treatment, how is a client to decide what recovery activities to include in his plan? This is where the therapist's clinical judgement based on the notion of matching the person to the optimal treatment strategy, may work to the client's benefit.

Recent research supports an integrated treatment approach using self-help with psychological and psychopharmacological approaches ( Earle 1995, Harnell, 1995). Lennon (1994) describes how the Integrated Treatment Program for Paraphiliacs (ITPP) program combines a strong cognitive-behavioral component, a relapse prevention approach plus a

treatment modality that is highly accountable and oriented to outcome research while integrating the 12-steps into the treatment regime. Mark Schwartz (1994) points out that therapeutic programs that limit their treatment options to reductionistic and mechanistic views of sexual compulsivity are not sufficient to bring total rehabilitation to an individual. He has found that these methods are more successful when integrated within a comprehensive framework that draws upon many treatment philosophies, including systemic, trauma-based, addictionology, psychodynamic, gestalt, and feminist-humanistic conceptualizations.

### **Action Stage: Do It**

This is the stage of treatment psychotherapists and addiction counselors are usually most comfortable in addressing. Setting priorities for action is an important function of therapy at this time. Having the client initiate group therapy or group contact is essential. The limitations of individual therapy will become obvious as the client begins to integrate sexual dependence recovery into his day to day life. This kind of significant life change needs to be discussed, processed and supported. Whether in twelve-step groups, group psychotherapy for sexual dependency or a psychoeducational program, contact with other people who are also motivated for recovery will be a significant source of support for the client.

Setting an expectation for group therapy early in the contemplative stage can simplify the client's later acquiescence to this treatment modality. By the time a person has reached the action stage, any ambivalence regarding group therapy should have been explored. It is suggested that clients in group therapy have a separate individual therapist. Individual therapy allows group participants to process significant issues in the privacy of individual therapy before bringing them to a group session.

## **Maintenance and Relapse: Ongoing Management of Recovery**

The skills required to maintain any changes in the action stage may be different from the skills required to make the change initially. For example, a sexually compulsive man who achieves abstinence for two continuous months for the first time in his 15-year history of sexually compulsive behavior may experience many unaccustomed emotions. The excited feelings of success in response to his extended sexual sobriety are counterbalanced with feelings of boredom, irritability and increasing anxiety. He must now learn to recognize and manage many new feelings. He may also begin to reveal the symptoms of an untreated anxiety disorder that has been driving his compulsion all these years. Although he may eventually relapse, the insight gained during this abstinence serves to solidify his determination for continued recovery.

In ongoing treatment, the important factor in a relapse is the response by the client and the therapist to the relapse. Relapses require the client to contemplate what led up to relapse and become determined to work to return to a maintenance level of functioning. This cycle will be repeated often as healing progresses. New treatment options may be added. Early treatment issues may become resolved, and the client may expand his definition of abstinence. Certain behaviors that were once high risk may now be seen as abstinence breaking behaviors. A client who continues to masturbate but struggles with using mental memories of previous compulsive sexual situations as erotic imagery may decide that this is now a slip in his abstinence. Men taking psychotropic medications could decide to stop their prescription after consultation with their physician. Even if these choices lead to relapse, the important treatment goal is to help the client avoid discouragement and demoralization in response to this temporary setback. The

therapist helps the client by normalizing the relapse and reframing it as an educational event in recovery.

Most treatment for sexual dependency takes time. Many clients are actively involved in therapy and self-help support for five or more years to maintain enduring periods of abstinence and recovery. For the recovering substance abuser who has already achieved years of chemical sobriety, finding the motivation to sustain that kind of commitment to healing his sexual life takes a great deal of patience and support. Additionally, the recovering substance abuser may have adjusted to a certain degree of pride in his recovery and find it painful to run into the judgmental and dismissive social context that currently exists for sexual dependents in most communities.

## **Conclusion**

Treatment of substance abusing men with sexual dependency is still an emerging clinical specialty. The paradigms for understanding these behaviors are still openly debated. Varying theories can result in particularly complex treatment considerations when a recovering addict or alcoholic committed to the 12-step model for chemical addiction now must address sexual dependency. Use of motivational interviewing strategies is a useful way to help a client with sexual dependency issues. The change model also helps the clinician avert potential pitfalls associated with a rigid adherence to a narrowly defined course for treatment. This chapter reviewed therapeutic techniques for engaging the newly diagnosed sexually dependent male client. It is hoped that focusing on the early stages of treatment will empower clinicians who may currently be avoiding or dismissing symptoms of sexual dependency in their substance abusing clients.



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