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Addictive Sexual Disorders

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Indulgence in the gratification of sexual desires and appetites to excess has been a major subject in literature, myths, and the creative arts from the beginning of recorded history. One example of the hypersexual predatory male is Don Juan, the legendary lover of many women, who suffered a multitude of adverse consequences, including death, as a result of his behavior. He is immortalized as the sexual athlete who worshipped the female body as the ideal object of desire, created for him to be consumed and ravished, and who had to make his escape from each one before potential engulfment by intimacy in a relationship. His story was immortalized in the plays of Corneille, Molière, Shaw, and Rostand, in Byron's unfinished poem, and in Mozart's *Don Giovanni*. He has become an infamous symbol for a hedonistic, narcissistic male who engages in recurrent sexual affairs. Women with culturally defined excessive sexual appetite were given the diagnosis of nymphomania, a term no longer in clinical use.

We have evolved into a society obsessed with the pursuit of pleasure and materialism—and for some, sexual materialism. In our sensually driven society, sexual excesses and deviances are regularly reported by the media and served up as entertainment in books, movies, and television. Corporations have learned through advertising campaigns that sex sells. The majority of adolescents, adult men, and women in our society can engage in fantasy and seductive behavior without significant consequences to their personal or professional life. However, for some, it is not possible to limit the intensity of their desire or expression of sexual behavior. For them, sexual excesses can become addictive in nature and represent a serious mental disorder.

A distinction must be made between a situational and a pervasive use of sex. Two surveys[1, 2] confirm that unmarried persons have more sexual partners than married people. For most, sexual variety is situational. Others, dealing with a life crisis such as the breakup of a relationship, may find themselves using sex compulsively for a brief period. For those with addictive sexual disorders, on the other hand, sex is the pervasive organizing principle of their lives.

Current Nosology According to the Diagnostic and Statistical Manual of Mental Disorders

The DSM-IV[3] classification of sexual disorders includes sexual dysfunctions and paraphilias. The sexual dysfunctions are characterized by disturbance in sexual desire and in the psychophysiological changes that constitute the sexual response cycle and cause marked distress and interpersonal difficulty. The sex-

ual dysfunctions include sexual desire disorders, sexual arousal disorders, orgasmic disorders, sexual pain disorders, sexual dysfunction due to a general medical condition, substance-induced sexual dysfunction, and sexual dysfunction not otherwise specified (NOS).

The paraphilias are characterized by recurrent intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The paraphilias include exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilia NOS.

Gender identity disorders are characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one's assigned sex.

Sexual disorder NOS is included for coding disorders of sexual functioning that are not classifiable in any of the specific categories. It is important to note that notions of deviance, standards of sexual performance, and concepts of appropriate gender role can vary from culture to culture.[3]

The essential feature of impulse control disorders is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to oneself or to others. For most of the disorders in this section, the individual feels an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification, or relief at the time of committing the act. After the act, the person may or may not feel regret, self-reproach, or guilt.[3]

The types of sexual improprieties and excesses that are considered addictive sexual disorders can usually be classified into one of three major categories: paraphilia, impulse control disorder NOS, or sexual disorder NOS. When the behavior does not fit easily into one of these categories and is not considered a manifestation of some other DSM-IV axis I diagnosis, then it is reasonable to use the work-related problem (V 62.2) or relationship problem (V 6.) descriptors. Frequent and infrequent DSM axis I diagnoses associated with sexual excesses are presented in Table 48–1. It is helpful to complete the differential diagnosis on axis I before considering axis II and axis III. Sexual disorders, impulse control disorders, and paraphilias, when identified, should be described as precisely as possible. If the NOS category is used, it is important to apply appropriate descriptors that define the features observed. In our experience, the most frequent features noted in addition to specific paraphilic behaviors are those of addiction, exploitation, predation, romance, coercion, professional misconduct, sexual offense, and sexual assault. The severity of the disorder, the duration, the current level of activity, and amenability to treatment should also be presented. In the differential diagnosis of sexual improprieties and excesses, axis II characterological disorders and traits are often contributory or may be considered the primary cause of paraphilic sexual behavior.

Table 48–1. AXIS I DIFFERENTIAL DIAGNOSIS OF EXCESSIVE SEXUAL BEHAVIORS

Common	Infrequent
Paraphilias	Substance-induced anxiety disorder (obsessive-compulsive symptoms)
Sexual disorder NOS	Substance-induced mood disorder (manic features)
Impulse control disorder NOS	Dissociative disorder
Bipolar affective disorder (type I or II)	Delusional disorder (erotomania)
Cyclothymic disorder	Obsessive-compulsive disorder
Posttraumatic stress disorder	Gender identity disorder
Adjustment disorder [disturbance of conduct]	Delirium, dementia, or other cognitive disorder

NOS, not otherwise specified.

A discussion of these disorders is included in this text on addiction psychiatry because they often have distinct parallels with other addictive disorders, commonly coexist with substance-related disorders, may themselves have features associated with addiction, and may respond to an addiction model of treatment and therapy. Unrecognized and untreated symptoms of these sexual disorders currently are frequently being recognized as significant factors leading to return to substance use in substance-related disorders. Compulsive sexual behavior has significantly contributed to the growth of the current epidemic of acquired immunodeficiency syndrome.

Evolution of the Addiction Model

Bill Wilson, in his classic Big Book,[4] describes an alcoholic's difficulties with sexual behavior.

> "Now about sex. Many of us needed an overhauling there. But above all, we tried to be sensible on this question. It's so easy to get way off the track. Here we find human opin-

ions running to extremes—absurd extremes perhaps.... We do not want to be the arbiter of anyone's sex conduct. We all have sex problems. We'd hardly be human if we didn't. What can we do about them?

We reviewed our conduct over years past. ... We got this all down on paper and looked at it. In this way we tried to shape a sane and sound ideal for our future sex life. We subjected each relation to this test—was it selfish or not? We asked God to mould our ideals and help us to live up to them....Whatever our ideal turns out to be, we must be willing to grow toward it.... Suppose we fall short of our ideal and stumble? Does this mean we are going to get drunk? It depends on us and on our motives.... If we are not sorry, and our conduct continues to harm others, we are quite sure to drink. We are not theorizing. These are facts out of our experience.

To sum up about sex: We earnestly pray for the right ideal, for guidance in each questionable situation, for sanity, and for the strength to do the right thing. If sex is troublesome, we throw ourselves the harder into helping others. We think of their needs and work for them. This takes us out of ourselves. It quiets the imperious urge, when to yield would mean heartache."

Clearly, even in the early development of Alcoholics Anonymous (AA), it was difficult for many to work the 12-step program of AA without coming to terms with their sexual behavior and applying the principles of the program to this as well as to their drinking.

In proposing an addiction framework, Orford[5] reviewed some examples of excessive sexual behavior and concluded that "a theory of dependence must take into account forms of excessive appetitive behavior which do not have psychoactive drugs as their object." His analogy, in a 1985 book,[6] is still relevant today:

> "Debate over definitions in this area is intriguingly reminiscent of debates on the same subject when drug-taking, drinking, or gambling are under discussion. In none of these areas is there agreement about the precise points on the continuum at which normal behavior, heavy use, problem behavior, excessive behavior, 'mania' or 'ism' are to be distinguished from one another. When reading of the supposed characteristics of the 'real nymphomaniac,' one is haunted by memories of attempts to define the 'real alcoholic' or the 'real compulsive gambler.'"

Carnes[7] posited that out-of-control sexual behaviors represent an addiction and defined sexual addiction as a "pathological relationship with a mood-altering behavior." The emphasis on the *behavior* or the *experience* as causation rather than on a particular chemical was earlier supported by Peele, who in a popular book[8] described addiction as having as much to do with love as with drugs. After critically reviewing research on addiction, he concluded,[9] "Drug addiction is based on the experience a drug gives a person and the place this experience has in the person's life. Anything that produces a comparable experience can likewise be addictive." Ironically, Peele has become an outspoken critic of the epidemic of addiction in America. Persons who are dually addicted to drugs and to sexual experiences describe a euphoria during their sexual acting out similar to that experienced when using mood-altering chemicals.

Quadland[10] characterized the disorder as sexual compulsivity, whereas Barth and Kinder[11] suggested the term *sexual impulsivity* and reserved the term *addiction* only for substance dependence. Schwartz,[12] noting the high frequency of sexual victimization of children who later become sexually compulsive, views sexual compulsivity as an aspect of posttraumatic stress disorder. According to Coleman,[13, 14] sexual excesses represent a variant of obsessive-compulsive disorder (OCD). Countering this view, Shaffer[15] identifies psychodynamic distinctions between addiction and OCD:

> "The loss of insight among addicts and the maintenance of discrimination among OCD sufferers distinguishes these populations. While the excessive behavior patterns of OCD are disconnected from the dysphoric affect that energizes their activity, addictive behavior remains attached to these noxious emotions. Consequently, addicts *escape* their discomfort by acting out through excess behavior patterns, while OCD patients *avoid* the conscious experience of psychic pain through repetitive intemperate activity."

Renshaw[16] presented a primarily negative critique of the concept of sexual addiction, and Levine and Troiden[17] believed that sexual compulsivity was altogether a myth. DSM-III-R[18] identified sexual addiction under the psychosexual disorders, NOS descriptor, but this reference was dropped in DSM-IV, a reflection of the continuing controversy about the addiction model. In addiction medicine, the existence of sexual addiction (and of all so-called process addictions) remains theoretical[19] and continues to be questioned by many. Further research is required to establish this entity as an accepted disease.

Although sexual addiction is not classified in DSM-IVr as a mental disorder, a diagnostic

Table 48–2. DIAGNOSTIC CRITERIA FOR SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. Markedly diminished effect with continued use of the same amount of the substance
(2) Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance
   b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
(3) The substance is often taken in larger amounts or over a longer period than was intended.
(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.
(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
(6) Important social, occupational, or recreational activities are given up or reduced because of substance use.
(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

From the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Association, 1994, p 181.

framework for the use of the term can be extrapolated from the DSM-IV diagnostic criteria for substance dependence. These criteria are listed in Table 48–2. According to the manual, three of seven criteria must be met for a diagnosis of substance dependence. If the term *sexual fantasy, desire,* or *behavior* is substituted for *substance use,* these diagnostic criteria can be used to define what we are considering addictive features of sexual disorders.

Goodman[20, 21] proposed a set of diagnostic criteria for addictive disorders that could be applied to either behavior or substance use (Table 48–3). By his definition of addiction, any behavior that is used to produce gratification and to escape internal discomfort can be engaged in compulsively and can constitute an addictive disorder. The similarities between his proposed criteria and DSM-IV are self-evident. Both define the essential elements of addiction as loss of control, continuation despite adverse consequences, and obsession.

Multiple Addictions, Switching Addictions

Sexual fantasy or behavior and substance use are often combined through the repetition of ritualized behavior. When one wishes to engage in sexual activity, mood-altering substances can be used ritualistically to (1) reenact scenarios from movies, books, fantasy, or past experience; (2) create mood and intensify sexual pleasure; (3) decrease inhibitions and fears; (4) treat sexual dysfunction or performance anxiety; (5) permit the expression of sexual aggression or paraphilia; or (6) provide a later rationalization or excuse for shameful or objectionable behavior. Mood-altering substances can be used ritualistically alone or with a potential sexual partner to (1) reenact scenarios from movies, books, or past experience; (2) increase the partner's vulnerability; (3) decrease inhibitions; (4) attempt to overcome a

Table 48–3. CRITERIA FOR ADDICTIVE DISORDER

Recurrent failure to resist impulses to engage in a specified behavior
Increasing sense of tension immediately before initiating the behavior
Pleasure or relief at the time of engaging in the behavior
At least five of the following:
1. Frequent preoccupation with the behavior or with activity that is preparatory to the behavior
2. Frequent engaging in the behavior to a greater extent or for a longer period than intended
3. Repeated efforts to reduce, control, or stop the behavior
4. A great deal of time spent in activities necessary for the behavior, engaging in the behavior, or recovering from its effects
5. Frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations
6. Important social, occupational, or recreational activities given up or reduced because of the behavior
7. Continuation of the behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior
8. Tolerance: need to increase the intensity or frequency of the behavior in order to achieve the desired effect, or diminished effect with continued behavior of the same intensity
9. Restlessness or irritability if unable to engage in the behavior

Some symptoms of the disturbance have persisted for at least 1 month or have occurred repeatedly for a longer period.

From Goodman A: Diagnosis and treatment of sex[illegible] diction. J Sex Marital Ther, 19(3):225–242, 1993.

partner's resistance, objections, or sexual dysfunction; (5) manipulate and control events; (6) promote emotional numbness; (7) distort reality and memory; or (8) provide compensation for sexual services.

When a person develops a pathological relationship with mood-altering substances and behaviors, he or she typically goes through multiple cycles of "acting in" and "acting out," moving from satisfying cravings in excess to abstinence or avoidance. When acting out, boundaries collapse, one is physically present but emotionally absent, anger is expressed either actively or passively, and life becomes chaotic. When one moves to the opposite extreme and acts in, boundaries become rigid, one becomes physically or emotionally isolated from others, experiences fear and anxiety, and finds life dull and empty. One then moves from acting in to acting out, from being in control to being out of control. Increasingly polarized extremes intensify pain and suffering. Among sexual disorders, acting in can present as a sexual desire disorder, sexual arousal disorder, or orgasmic disorder; acting out is expressed through paraphilic and nonparaphilic sexual behavior.

Addictive disorders tend to coexist. Nicotine dependence, for example, is highly correlated with alcohol dependence. The same is true of sex addiction and chemical dependence. In an anonymous survey of 75 recovering sex addicts,[22] 39% were also recovering from chemical dependence, 32% had an eating disorder, 13% characterized themselves as compulsive spenders, and 5% were compulsive gamblers. Only 17% believed they had no other addiction. Similar percentages have been reported by Carnes.[23] In another study,[24] 70% of cocaine addicts entering an outpatient treatment program were found also to be engaging in compulsive sex.

In Irons and Schneider's population of health professionals assessed for sexual impropriety,[25] those with addictive sexual disorders were almost twice as likely to have concurrent chemical dependence (38% prevalence) than were those who were not sexually addicted (21%). Thus, the presence of sexual compulsivity was a comorbid marker for chemical dependence.

Addictive sexual disorders are frequently found during assessment for chemical dependence. For example, during a 4-year period in one treatment facility, approximately 33% of the chemically dependent patients were also found to be sexually compulsive, as were approximately 25% of the chemically dependent physician patients.[26] Many of the patients at this facility had been previously treated for drug dependence, but the dually addicted patients had more relapses before the present admission. In the presence of concurrent drug and sexual dependence, relapse or failure to treat one of the addictions is likely to lead to relapse in the other. This conclusion is supported by the earlier finding by Washton[24] that many of his cocaine-dependent patients had become trapped in a reciprocal relapse pattern, in which compulsive sexual behavior precipitated relapse to cocaine use and vice versa.

A related phenomenon in early recovery is the tendency to switch addictions or to intensify a concurrent addiction. A well-known example is the increased use of cigarettes, caffeine, and sugar by new AA members. "Thirteenth stepping," the seeking of sexual partners at 12-step meetings, may in some cases represent a flight into addictive sexual activity. Substituting one addiction for another may temporarily help an addict refrain from drinking, but this approach is unlikely to lead to sustained sobriety.

Milkman and Sunderwirth, in their book *Craving for Ecstasy*,[27] described three basic types of neurobiochemical responses we may experience when we pursue any given desire to gratification—arousal, satiation, or an increase in fantasy or preoccupation with the object. Mood-altering behaviors can create the same central nervous system responses as mood-altering substances. In the pursuit of satisfaction, one may often combine behaviors with the use of drugs. We are just beginning to understand brain neurobiochemistry. We currently associate arousal with the neurotransmitters norepinephrine and dopamine, satiation with gamma-aminobutyric acid and endorphins, and fantasy with serotonin. It is important to observe that sex can easily fit into any or all of the foregoing categories, making it an extremely powerful mood-altering activity. Some individuals may have a propensity for behavior that provides a sense of excitement, such as gambling, using stimulants, or participating in high-risk stunts. Others may prefer sedation through self-medication with alcohol or satiation through sexually exploitive relations or compulsive overeating. Still others escape via fantasy, use of psychedelic drugs, preoccupation with work, or compulsive religious practice pursued to excess. When kept in balance, these activities may provide comfort and status, assuaging the sense of unworthiness. When carried to extremes, however, they often

represent a personal variation on the theme of addiction.

Disease Expression and Progression

Carnes[28] described the progression of untreated sexual addiction. The *initiation phase* is characterized by an exceptionally intense impact of observed or experienced sexual activities during development as an adolescent and young adult. At some point, sex becomes the drug of choice, used to escape or cope. Catalytic environments and catalytic experiences lead to the *establishment phase,* in which there is repetition of an addictive cycle of preoccupation, ritualization, sexual acting out, then despair, shame, and guilt, which are alleviated by renewed preoccupation. With time, the addiction may *escalate,* with greater intensity, more frequency, more risk, and greater loss of control. The behavior may intermittently *de-escalate,* at times through the means of substituting another addictive behavior (such as a period of heavy drug use), or it may progress to the *acute phase,* when the individual becomes alienated from significant others and is constantly preoccupied with the addiction cycle. In some, the addiction becomes immutable and behavior is limited only by opportunity, physical consequences, or incarceration.

Physical Manifestations

Sexual addicts may present with various physical health problems such as genital injury as a direct result of sexual activity; sexually transmitted diseases (STDs) including hepatitis, human immunodeficiency virus (HIV) infection, herpes simplex, gonorrhea, syphilis, and *Chlamydia;* physical injuries associated with engagement in high-risk sexual behaviors or sadomasochistic activity; unnecessary operations (such as breast implants, hair transplants, plastic surgery, liposuction) used to enhance sexual appeal; binge-purge cycles in an attempt to regulate weight; abuse of agents reputed to be sexual performance enhancers ("poppers," other inhalants, yohimbine, papaverine); and unwanted pregnancies or the complications of abortions. Associated secondary (reactive) mental disorders include depressive disorders, posttraumatic stress, dissociative disorders, and anxiety disorders. Self-destructive and self-defeating behavior is not unusual, including suicidal ideation or suicide attempts.

The use of alcohol and other drugs in conjunction with sexual activity is associated with an increased risk of HIV infection, even when drugs are not injected. Among heterosexuals entering alcohol treatment in San Francisco, unsafe sexual practices were common: 54% had multiple sexual partners in the previous year and 97% of nonmonogamous respondents did not use condoms during all sexual encounters.[29] In a review of 16 epidemiological studies relating crack cocaine use, sexual behavior, and STDs[30] 15 of the studies reported a connection, often related to an exchange of drugs for sex and lack of self-care while high on the drug. An additional reason, not mentioned in this review, was the likelihood that the sexual behavior was compulsive in many of the cocaine users. Given the high concordance between cocaine addiction and sex addiction,[24] it is clear that both addictions must be addressed in order to decrease a cocaine addict's risk of HIV disease.

Compulsive sexual behavior, even in the absence of drug use, is often unsafe. Addicts report that once they find themselves in the ritual phase of the addictive cycle, they are on automatic pilot and do not even think about safe versus unsafe sex. It is only after the sexual contact is completed that remorse, guilt, and fear of infection set in.

Disease Expression in the Family

Addictive sexual disorders, like substance addictions, affect an entire family directly or indirectly. Substance addiction correlates directly with an increase in domestic violence and family conflict and in accidents around the home and in automobiles. Families in which a member has a sex addiction but not chemical dependence tend to appear less chaotic and fragmented early in the course of the disease. However, as the stress and consequences of addiction accumulate, family members of both types of addicts often react with common behaviors.

A number of self-help books describe how various family members may respond to addiction—for example, the phenomenon of codependence and the "adult child" from an alcoholic family. These stereotypes represent the adaptation of an individual's personality to the experience of living with addiction. The evolution of compulsive and maladaptive b-

haviors in family members is recognized less often. Profound shame, unconscious denial, and minimization of the consequences, for example, may lead the spouse to try to bolster self-esteem through excessive involvement in vocational, religious, or parenting activities or through episodes of compulsive shopping or eating.

Addiction and coaddiction often have their roots in a dysfunctional family system in which the child is either abused or neglected. In Carnes' survey[23] of recovering sexual addicts, 83% reported they had been sexually abused as children. For such children, a confusion of sex with nurturing becomes a lifelong problem. When the survey respondents were asked to categorize their family of origin along the two axes of Olson and colleagues' circumplex model of marital and family systems,[31] a clear majority (68%) fell into just one of the 16 cells, the rigid disengaged family. The rigidly religious family is a prototype and had inflexible rules and insufficient nurturing. Sex addicts' families of origin typically have a multigenerational history of addictions, with various combinations of addictions to chemicals, sex, food, work, and gambling.

Partners of sex addicts most commonly come from a family background remarkably similar to that of sex addicts[23, 32]—a dysfunctional family often riddled with addiction problems, where their emotional needs as children were not met. Many were sexually abused and grew up believing that sex is the most important sign of love or that love must be earned with sex; alternatively, they may fear sex and have disorders of sexual desire, arousal, or orgasm. They have a great need for approval from others and have difficulty setting appropriate boundaries. They often have a history of relationships with addicts or other emotionally unavailable people. Choosing a sex addict for a relationship is generally no accident.[32] An example of a couple whose dysfunctions complement each other is an addict who prefers prostitutes to marital sex, and his wife, who was sexually abused in childhood, has no interest in sex and is grateful for her husband's lack of sexual interest in her. This wife represents the other extreme from disorders of sexual excess and struggles with a sexual disorder that inhibits desire or sexual function.

The sexual coaddict (partner of an addict) is often intensely fearful of abandonment and is overinvested in the relationship. Coaddicts may be aware of serious family problems but often believe that they are responsible for the problems and that if they try hard enough they can solve them. With the addict's top priority being the addiction and the coaddict focusing on the addict, the children may receive inadequate or inconsistent nurturing.

One child may become the family hero and eventually a compulsive worker who speculates on commodities and periodically flies off to Las Vegas—with disastrous financial consequences. Another child may develop an eating disorder, and a third may indulge in a series of devastating sexual affairs. Of course, all the children vow that "it will never happen to me," and family shame and consternation are reinforced when yet another family member succumbs to addictive disease.

When addiction is evident, developing appreciation of how these patterns are expressed within the family may promote better self-understanding for all. Addiction treatment, family therapy, and the experience, strength, and hope found in 12-step programs often provide comfort and needed support for addicts and their families. As people at risk for addiction come to understand the creative and destructive forces that have shaped their family, they may gain greater freedom to make conscious, informed choices that promote personal and family health.

Dynamic Formulation

Stoller[33] described how a personal, specific vulnerability may develop during male separation and individuation. Disruptions or failures in integration result in a psychological wounding, unique to the individual. Once this wound is formed, it has an autonomous existence that may be expressed years later as personal insensitivity toward others, ambivalence in complex, demanding relationships, or misogyny.

We experience certain critical events, which Maslow called *peak experiences*, that have a profound effect on us for the rest of our lives. Some of these are not peaks, however; they are canyons. Each of us can recall them, and each brings up specific emotions and images. Some of them may be sexual and may have profound effects on our future sexuality and intimacy, such as the time when, as children, we explored and compared anatomy with an age mate; the first time we masturbated; the first time we looked at pornography; our first sexual feelings; our first experience of love; the pleasure of touching another's genitalia; the time we were uncomfortable with the embrace

of our mother or father; the night when we were unable to perform sexually; the sexual partner we used and then discarded; and the person who used or rejected us. Some of these experiences are suffused with shame and guilt. Others we recall with warmth, joy, and perhaps a wish to return to that moment once again. Hudson and Jacot[34] believe that such experiences are a central feature in mental architecture and exert a formative influence on imaginative needs. Some may be carried forward in life as wounds that remain with us as an inner source of unresolved tension, expressed in characteristic biases or patterns, unique to the individual. Such wounds are evidenced by a loose-knit group of telltale signs. Needs and desires related to these wounds tend to reassert themselves over time, although their influence can be temporarily overridden. They have protean forms of expression, both creative and destructive.

Years later, wounds may be reopened, perhaps derepressed when our interaction with another creates associations with images or feelings we experienced long ago. We may not recall the wound directly, but unresolved feelings from the past affect our current emotions and actions. We are often experiencing the effects of a wound when we feel paradoxical feelings toward our sexual partner. On one hand, we might revere and adore the partner, and on the other, fear the power he or she has over us. We may find ourselves in a conflict about what we believe is healthy sexuality and that which is unhealthy and potentially addictive. When our sexual interactions with another leave us with a Jekyll-and-Hyde feeling about ourselves and sex brings a sense of unreality, isolation, and grief, further exploration of the old wound is avoided or thoughts and emotions are repressed.

Young boys who are sexually abused often find the experience confusing. Films such as *The Summer of '42*, in which a teenage boy is seduced by an attractive, newly widowed woman, promote the view that such a boy "got lucky." Yet the boy may find the experience frightening. He may respond by developing chronic anger at women and may detach emotionally from sexual experiences, considering them nothing more than another "score." He may find himself making a clear distinction between the idealized "good" woman and the deprecated "bad" woman, developing a "madonna-whore complex," which may make it difficult for him in later years to enjoy a sexual relationship with a woman he loves.

Emotional abuse in childhood was experienced by 97% of sex addicts in a large survey.[23] In many homes, the abuse took the form of criticism and humiliation by a parent, of never being able to measure up. A boy who grows up feeling inadequate may seek to compensate by having many female partners. The goal of his behavior is not to have many orgasms but rather to receive validation of his sexual attractiveness from many women.

These early injuries may be sexual, but they are by no means invariably so. Whatever their source, these wounds need to be honored and nurtured; some have to be recalled and brought to consciousness so that we can better understand ourselves and others. To develop insight into the nature of addictive sexual disorders, appreciation of these wounds is crucial. As portrayed in the Arthurian legend of the Fisher King and effectively interpreted dynamically by Johnson,[35]

> "As in the story of the Fisher King coming upon the roasting salmon, a boy in his early adolescence touches something [of spiritual/sexual nature] too soon. He is unexpectedly wounded by it and drops it immediately as being too hot. His first contact with what will be redemption for him in later life is a wounding. This is what turns him into a wounded Fisher King. The first touch of consciousness in a youth appears as a wound or suffering. Most western men are Fisher Kings. Every boy has naively blundered into something that was too big for him. He proceeds halfway through his masculine development and then drops it as being too hot. Often a certain bitterness arises, because like the King, he can neither live with the new consciousness he has touched or entirely drop it. Every adolescent receives his Fisher King wound. He would never proceed into consciousness if it were not so."

The roots of sexual addiction often lie in the absence of adequate parenting, coupled with sexual abuse or a sexualized atmosphere in the home. Each young child must developmentally evolve through a narcissistic stage. When a child is sexually, physically, or emotionally abused or, by contrast, when abandoned or neglected, the child may become convinced that his or her misbehavior or inherent "badness" must be the cause of the adult actions; the alternative, that one's caregivers are unloving or unreliable, is intolerable to the child. Low self-esteem and shame are predictable consequences.

Sexual abuse affects sexuality in three areas[36]: (1) Sexual emergence in early adulthood—Survivors seem either to become [illegible] cially and sexually withdrawn or to plun[illegible]

into a phase of hypersexual and sometimes self-destructive sexual activity. In adulthood, they may continue this behavior, developing a full-blown sex addiction. Males may view their female partners merely as objects to be used and discarded; females may use sex to gain power over men. (2) Sexual orientation and influence—Males who have been abused by other males tend as adults to relate homosexually more often than do nonabused males.[36] In adulthood, some men may compulsively reenact the abuse with other males, even if they believe themselves to be primarily heterosexual.[37] Others may need to repeatedly prove their masculinity at the expense of a large number of female partners. (3) Sexual arousal, response, and satisfaction—Survivors of sexual abuse frequently lack sexual desire. Women in particular may develop sexual dysfunctions and may avoid sex throughout their adulthood. Some may remain celibate, marry a man who has low sexual desire or finds other sexual outlets, or turn to female partners. Some find they are comfortable sexually only when intoxicated; a majority of female alcoholics were sexually abused in childhood.

Victims of childhood abuse may themselves become victimizers. An important aspect of treatment of sexually addicted sex offenders involves resolution of their childhood trauma experience.[12, 38, 39]

Patterns of Sexual Addiction, Sexual Offense, and Sexual Exploitation

Based on a survey of nearly 1000 patients (81% male, 19% female) admitted for treatment of addictive sexual disorders, Carnes[23] found that out of 104 behavioral items, 10 behavior types emerged; each type had a specific sexual focus with common characteristics. The ten patterns and examples of each are listed in Table 48–4.

Carnes and colleagues[40] observed significant gender differences in the incidence of these behavior types. Under the influence of addiction, men tended to engage in behavioral excesses that objectify their partners and require little emotional involvement (voyeuristic sex, paying for sex, anonymous sex, and exploitive sex). A trend toward emotional isolation was clear. Women, in contrast, tended to be excessive in behaviors that distort power—either in gaining control over others or being a victim (fantasy sex, seductive role sex, trading sex, and pain exchange). Carnes and associates found that women sex addicts use sex for power, for control, and for attention. Similar conclusions were reached by Kasl,[41] who treated many women with addictive sexual disorders. Sex addiction, according to Carnes, seems to "intensify the wounds already present in each gender." In women,[42] these wounds involve power and victimization issues, whereas men have difficulty with bonding, intimacy, and the tendency to objectify others.

Carnes' typology of addictive sexual behaviors includes both paraphilic (exhibitionism, voyeurism, frotteurism [indecent liberties], pedophilia, sadism, masochism, sex with animals) and nonparaphilic behaviors (seductive role sex, anonymous sex). In other words, both paraphilia NOS and sexual disorder NOS can have addictive features. In his early writings, Carnes[7] separated addictive behaviors according to another criterion—the extent to which the behavior victimizes others. The

Table 48–4. PATTERNS AND THEMES OF SEXUAL ADDICTION

Fantasy sex: Items focused on sexual fantasy life and consequences due to obsession. Themes include denial, delusion, and problems due to preoccupation.
Seductive role sex: Items focused on seductive behavior for conquest. Multiple relationships, affairs, and unsuccessful serial relationships.
Anonymous sex: Engaging in sex with anonymous partners; having one-night stands.
Paying for sex: Paying prostitutes for sex; paying for sexually explicit phone calls.
Trading sex: Receiving money or drugs for sex or using sex as a business. Highly correlated were swapping partners and using nudist clubs to find sex partners.
Voyeuristic sex: Items focused on forms of visual sex, including pornography, window peeping, and secret observation. Highly correlated with excessive masturbation, even to the point of injury.
Exhibitionist sex: Exposing oneself in public places or from the home or car; wearing clothes designed to expose.
Intrusive sex: Touching others without permission; using position or power (e.g., professional, religious) to sexually exploit another person; rape.
Pain exchange: Causing or receiving pain to enhance sexual pleasure. Use of dramatic roles, sexual aids, and animals were common themes.
Exploitive sex: Use of force or partner vulnerability to gain sexual access.

From Carnes P: Don't Call It Love: Recovery from Sexual Addiction. New York, Bantam Books, 1991, pp 42–44.

greater the victimization or the risk involved, the greater the addict's lack of control and unmanageability. Level one comprises behaviors regarded as normal, acceptable, or tolerable, such as masturbation, visits to pornographic bookstores and theaters, anonymous sex in parks and bathrooms, and prostitution. Level two includes nuisance crimes such as exhibitionism, voyeurism, obscene telephone calls, and frotteurism. Level three behaviors are serious crimes such as incest, child molestation, or rape. Addicts who are compulsive at level three are usually also compulsive at levels two and one; level two addiction is generally accompanied by addictive behaviors at level one as well. Although one specific behavior type may precipitate the crisis that brings a sexual addict to intervention, experience has shown that when a thorough sexual history is taken, an average of three compulsive sexual behaviors is found.

Sexual offense is a legal rather than a clinical term and refers to behaviors that directly traumatize and harm another individual. Sex offenders exploit available power, influence, opportunity, or vulnerability to gain control over their victim and advance their sexual agenda. Although sex offenses such as rape by physical force and pedophilia *may* result from sexual addiction, many sex offenders are not sexually addicted. Blanchard[43] examined the prevalence of sexual addiction among 109 imprisoned male sex offenders at the Wyoming State Penitentiary. Based on written instruments, personal interviews, and review of arrest records and presentence reports, he found that 55% of the sex offenders were sexually addicted. Of 63 child molesters, 71% were sexually addicted, compared with 39% of the rapists. Sex offenders who do not meet the diagnostic criteria for an addictive sexual disorder often have significant characterological pathology, such as antisocial, paranoid, schizotypal, or narcissistic personality disorders. Such individuals are sometimes eager to flee into illness and claim to be sexual addicts to excuse and justify their sexual assaults. In such situations, the self-proclaimed diagnosis should be viewed with skepticism unless strongly supported by clinical experience. Blanchard[43] also reported that sexually addicted offenders had different antecedent emotions than nonaddicts. The former felt sad, alienated, unworthy, and socially inadequate and needed constant signals of acceptance and approval; in contrast, the nonaddicted offenders were outwardly angry and had a hostile attitude toward society, especially toward women. The nonaddicted offenders had a greater incidence of violent assault against age mates. Many in both groups had suffered abuse during childhood, but the sexually addicted offenders had suffered less violent forms of maltreatment.

Compared with nonaddicted sex offenders, sexually addicted offenders have a higher number of prior offenses and fewer intrusive offenses, engage in rituals around offense behaviors rather than impulsive actions, have a higher level of shame about the offense behavior, make greater use of pornography, have a higher incidence of concomitant substance addictions, feel unworthy and out of control (whereas nonaddicted offenders feel anger, frustration, and hatred), are more in touch with their own past victimization, and are likely to have a history of child sexual abuse or sexualized home environment (whereas nonaddicted offenders are more likely to have a history of childhood physical abuse).[44]

That there are at least two different subsets of sex offenders with differing dynamics may explain why traditional one-size-fits-all models for treatment of sex offenders have been so notoriously unsuccessful. New models that selectively and individually incorporate behavioral, cognitive, and addiction approaches for treating these different groups are being developed[45, 46] and should lead to improved outcomes.

Professional Sexual Exploitation

One category of sexual offending that is receiving increasing attention is sexual exploitation by professionals, in which violation of a fiduciary relationship is used to advance a personal sexual agenda. Examples of such professionals include physicians, psychotherapists, counselors, teachers, lawyers, dentists, and ministers. There are two primary categories of sexual exploitation of power. *Professional sexual misconduct* is the overt or covert expression of erotic or romantic thoughts, feelings, or gestures by a professional toward a patient or client that are sexual or may reasonably be construed by the patient or client as sexual. *Sexual offense* is a nontherapeutic, nondiagnostic attempt by a professional to touch, or any actual contact with, any of the anatomical areas of a patient's or client's body commonly considered reproductive or sexual. Offending may also involve forcing or manipulating a client to touch the professional in these anatomical areas.

Professional sexual exploitation can occur within a diverse array of scenarios, examples of which are listed in Table 48–5. Gonsiorek[47] edited a text that provides a comprehensive review of current knowledge in this area, and Schoener[48] reviewed current experience with rehabilitation.

Professional sexual exploitation is surprisingly common, although often not reported by victims. Anonymous surveys of physicians and other helping professionals have consistently yielded a lifetime prevalence of 6% to 9% of those surveyed admitting to sexual contact with at least one patient or client[49–51]; 30% to 40% of respondents who had sexual contact with one patient or client admitted to such contact with more than one, suggesting a pattern of recurrent sexual exploitation. In addition to professionals who have had sexual contact with active patients or clients, many others have engaged in sexual contact with *former* clients, an activity that is also considered exploitive[52] and unethical.

Irons and Schneider[25] reported the results of an intensive inpatient assessment of 137 healthcare professionals (85% of them physicians, 98% male) referred because of allegations of personal or professional sexual impropriety. After assessment, half (54%) of the total group were found to have sexual disorder NOS with addictive features (i.e., to be sexually addicted). Two thirds (66%) of the entire group were found to have engaged in professional sexual exploitation, and of this subpopulation, two thirds (66%) were sexually addicted. Thus, addictive sexual disorders are a common feature of sex offending by professionals. In addition, one third (31%) of the entire group was incidentally found to be chemically dependent, a condition for which many had not been previously treated.

Although the incidence of antisocial personality disorder in incarcerated sex offenders is high, this characterological disorder is uncommon in sexually exploitive professionals. Among a group of 157 helping professionals assessed by Irons, only one had this disorder and another had antisocial personality traits (total 1.2%). The most common axis II disorder in this group of professionals was narcissistic personality disorder (9.5%), followed by dependent personality disorder (3.8%). In addition, 18.5% had a mixed personality disorder. Overall, 62 of the 157 consecutive professionals evaluated (39.5%), met the DSM diagnostic criteria for a personality disorder. Many more had axis II traits, in particular narcissistic (21.7%) and dependent (21.7%) personality features.

Contribution of Characterological Pathology

As we have shown, many cases involving sexual impropriety are associated with and at least partially attributable to characterological pathology, particularly when exploitation, assault, or sexual offense is involved. It is appropriate if not essential to diagnose a personality disorder during assessment or treatment. This characterological diagnosis can be the primary diagnosis, or the patient can be viewed as having comorbid conditions involving an axis I

Table 48–5. SEXUAL EXPLOITATION SCENARIOS

Therapeutic touch becomes erotic or is experienced by patient as sexual
Caretaking or emotional support extends beyond professional boundaries
Romantic enmeshment with patient
Use of power and position to advance sexual agendas
"Fatal Attraction" or enactment of a rescue fantasy
Paternal or maternal nurturance of a younger patient
Involvement with family member of patient
Frotteurism, voyeurism, or exhibitionism in a professional role
Unnecessary or overextensive genital examination
Rude/abusive/verbally inappropriate solicitation
Professional offers of sexually enhancing procedures
Personal sexual therapy for a patient's sexual or relationship problems
Cultural dissonance between professional and patient becomes sexualized
Molestation of patient who is physically, mentally, or emotionally unable to offer resistance or is under the influence of mood-altering substances or anesthesia
Attempt by professional to resolve conflicts involving sexual preference by sexual involvement with patient or client
Reenactment of patient or professional's incestuous desires or past sexual abuse

From Irons RR, Schneider JP: Sexual addiction: Significant factor in sexual exploitation by health care professionals. Sexual Addiction and Compulsivity 1:198–214, 1994.

diagnosis and an axis II diagnosis of characterological pathology. Many mental health professionals are reluctant to make a diagnosis of personality disorder, and such a diagnosis is viewed by some as a characterological curse—immutable, untreatable or poorly treatable, and auguring a poor prognosis. In our clinical experience, defects of character and other types of self-destructive or self-defeating behavior are often noted as part of addictive disease. If a patient is capable of honesty and at least partial insight, is able to identify characterological defects, and can work with them in steps 4 through 9 of a 12-step program, such defects are treatable using addiction model treatment and therapy. Dramatic characterological change is not infrequently observed as part of personal transformation achieved through dedicated participation in 12-step programs, insight-oriented or analytical therapy, and other avenues that promote spiritual awakening.

Evaluation for Sexual Addiction

All chemically dependent patients and all persons whose sexual behavior has been problematical should be screened for the presence of addictive sexual disorders. An appropriate starting place is the 25-item sexual addiction screening test developed by Carnes.[28] If 13 of the 25 questions are answered in the affirmative, the likelihood that an addictive sexual disorder is present is 96%. This tool must be used with caution in homosexual men, whose behavior and lifestyle are often characterized by secrecy and shame even though most are not sexual addicts. Also, the test has not been validated for women or adolescents. An additional adjunct to assessment is the checklist of collateral indicators that is reproduced in Table 48–6. Carnes compiled these indicators from research and therapy and believes that the presence of six or more collateral indicators is strongly suggestive of sexual addiction.

Because a multigenerational family history of addictive disorders is common among sex addicts, obtaining a genogram and a detailed biopsychosocial history can also assist diagnosis.

If the screening test suggests addiction, a more detailed sexual history should be obtained. One helpful tool is the Sexual Dependency Inventory, Revised,[53] a detailed, self-administered inventory that asks 184 questions about specific sexual behaviors and the frequency and power of each for the person. When given in the first 3 days after the initial intervention or admission, this inventory makes patients aware of the many areas in which their sexual behavior is out of control and helps break patients' denial about the seriousness of their life situation (Carnes P: Personal communication).

A thorough physical and neurological examination should be part of assessment. Persons who have had several sexual partners must be checked for HIV infection and other STDs. Female patients should have pregnancy testing. Rarely, endocrine disorders or central nervous system diseases such as a brain tumor or infection can cause a change in behavior.

The axis I differential diagnosis of sexual addiction was presented in Table 48–1. The clinical interview, along with standard psychological tests such as the Minnesota Multiphasic Personality Inventory and Millon and projective tests such as the Rorschach and Thematic Apperception Tests can help work through the differential diagnoses as well as define characterological pathology that can either exacerbate or simulate addictive disease.

Primary Treatment

Because a large percentage of persons with addictive sexual disorders are also chemically dependent, the initial decision often facing a treatment professional is which addiction to treat first. By the time many sex addicts seek help for this disorder, they are already in recovery from their substance dependence. If not, then regardless of which addiction is primary, the drug dependence must be treated first, or else sex addiction treatment is unlikely to be successful.

Decisions about inpatient versus outpatient primary care for addictive sexual disorders can be based on criteria analogous to the American Society of Addiction Medicine's *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders.*[54] Inpatient admission is appropriate for those who are unlikely to be able to engage in treatment as outpatients, are a danger to themselves or others, or have significant concurrent medical or psychiatric conditions requiring close observation.

Early treatment is similar to that for chemical dependence, comprising education about addiction in general and sex addiction in particular, a combination of group and individual therapy, introduction to 12-step programs and to mutual-help meetings, and, if possible,

Table 48–6. CHECKLIST OF COLLATERAL INDICATORS

1. Patient has severe consequences because of sexual behavior
2. Patient meets the criteria for depression and it appears related to sexual acting out
3. Patient reports history of sexual abuse
4. Patient reports history of physical and emotional abuse
5. Patient describes sexual life in self-medicating terms (intoxicating, tension relief, pain reliever, sleeping pills)
6. Patient reports persistent pursuit of high-risk or self-destructive behavior
7. Patient reports much greater sexual arousal with high-risk or self-destructive behavior than with safe sexual behavior
8. Patient describes pleasure or relief at time of sexual acting out but experiences despair afterward
9. Patient meets diagnostic criteria for other addictive disorders
10. Patient simultaneously uses sexual behavior in concert with other addictions (gambling, eating disorders, substance addiction, alcoholism, compulsive spending) to the extent that desired effect is not achieved without both sexual activity and other addiction present
11. Patient has history of deception around sexual behavior
12. Patient reports other members of the family are addicts
13. Patient expresses extreme self-loathing because of sexual behavior
14. Patient describes periods of time when all sexual interest and behavior cease
15. Patient has a pattern of bingeing followed by periods of being compulsively nonsexual
16. Patient is sexually excessive in some areas and compulsively nonsexual in others
17. Patient has few intimate relationships that are not sexual
18. Patient has attempted self-mutilation as an attempt to disrupt cycle
19. Patient is in crisis because of sexual matters
20. Patient has a history of crisis around sexual matters
21. Patient experiences anhedonia in the form of diminished pleasure for same experiences
22. Patient has mood lability around sexual behavior

From Carnes PJ: Personal communication, Minneapolis, 1995.

involvement of family members in family week, a program of education and confrontation. Shame, a major issue for sex addicts, is best addressed in group, where other recovering persons can provide support, confrontation, and shame reduction. Goodman[20] provides a review of the different aspects of treatment of sex addiction.

Recovery from sexual addiction is better viewed as analogous to recovery from eating disorders than to recovery from chemical dependence. Unlike the goal in treatment of chemical dependence, which most often is abstinence from use of all psychoactive substances, the initial therapeutic goal in addictive sexual disorders is abstinence only from compulsive sexual behavior. Development of healthy sexuality is a primary goal that is usually achieved only through continued commitment to a program of continued recovery and therapy. Early in the treatment period, it is suggested that patients refrain from all sexual activities, including masturbation, for 30 to 90 days. This enables them to learn that they can indeed survive without sex and allows them to get in touch with feelings that have been avoided and covered up with sexual activity. When they stop all sexual activity, some addicts report withdrawal symptoms similar to those experienced by cocaine addicts.

Pharmacotherapy has a definite place in the treatment of addictive sexual disorders. Some addicts report that the selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, sertraline, and paroxetine modulate the intensity of their sexual preoccupation and allow them to participate fully in treatment and self-help groups.[55, 56] For others, the tendency of the SSRIs to inhibit orgasm is a benefit. SSRIs are also useful, of course, in alleviating the depression that so often accompanies addiction. Progestational agents are occasionally used in the treatment of sex offenders.

Recovery Contracting with Sexual Addicts

PERSONAL

In the process of developing awareness of ritualized behavior and appreciation of powerlessness over compulsive sexual thoughts and actions, patients become ready and able to define certain bottom-line behaviors that they are willing to avoid as part of a continuing care contract. Engagement in one of these behaviors is considered either a slip or a relapse, depending on the behavior involved and the circumstances. Behavioral modification, by applying the 3-second rule to limit the length of time one focuses on an object or thought associated with sexual desire, and arousal re-

conditioning are also useful for some recovering addicts.

PROFESSIONAL

Some subgroups of sexually exploitive professionals have a better prognosis than others for return to professional practice. In contrast to professionals who have exploited primarily as an expression of an axis II characterological disorder, sexually addicted professionals who have successfully completed comprehensive assessment and primary treatment can often return to work without compromising public health and safety. Irons[57] devised a set of proposed contractual provisions for reentry. Such a contract can be part of a binding legal stipulation between the professional and a state professional licensing board or other regulatory agency and can define a standard care for potentially impaired healthcare professionals.

Course of Recovery Over Time

Compared with recovery from drug dependence, improvement in the quality of life of a recovering sex addict takes longer.[28] The first year is characterized by great turmoil. Most relapses, if they occur, take place in the second 6 months. Health, legal, occupational, and relationship consequences of the addiction take their greatest toll during the first year.

Because sex addicts were often sexually abused as children and because they have distorted ideas about sex, they generally lack experience that facilitates development of healthy sexuality. In the early recovery period, sex addicts and their partners frequently have sexual difficulties, often to a greater degree than they had during the active addiction phase.[22] Therapists can provide reassurance during this phase. If the compulsive sexual behavior was with same-sex partners, as is quite common even among men who identify themselves as heterosexual,[37] therapists can help patients work through conflicts about sexual preference.

In the second and third years, significant rebuilding starts. Patients experience improvement in career status, finances, friendships, and self-esteem. It is possible finally to define and work for healthy sexuality and intimacy in a relationship. In the fourth and fifth years, relationships with the significant other, parents, children, and life in general continue to improve.

Partners of sex addicts follow a similar path,[28] except that they experience their worst health problems and relapses to other addictions during the first 6 months. By the second 6 months, they begin experiencing improvement in self-image, career status, and communication with a partner. This means that for a couple working for recovery in the first year, each may be at a different phase, contributing to relationship stress. Couples need to be counseled to avoid making relationship decisions during this period; the couple relationship typically finds significant improvement only after this time.

Continuing Care

Like other addicts, sex addicts need ongoing support for establishing and maintaining a healthy lifestyle and avoiding relapse. Regular attendance at 12-step meetings (discussed later), coupled with ongoing therapy for dealing with shame, childhood trauma, false beliefs, and the consequences of past actions, all can facilitate recovery.

Lapses and relapses in the addictive sexual disorders often have more severe consequences than in substance dependence: A single incident of exhibitionism may lead to arrest or imprisonment; another sexual encounter may precipitate the end of the marriage. Accordingly, relapse prevention is a key component of treatment of sex addiction. Marlatt and Gordon's cognitive-behavioral approach to relapse prevention in drug dependence[58] has been adapted for the treatment of sex offenders. The volume edited by Laws[59] on relapse prevention for sex offenders is a very useful guide to treatment for all sex addicts.

Sex therapy is generally most effective at a later stage of treatment, in the second year and beyond. When treating patients with addictive sexual disorders, sex therapists may need to modify some of their beliefs (e.g., views on masturbation) and to honor recovery boundaries of clients.[60] Some traditional sex therapy techniques may also require modification. Irons[61] described healthy sexuality in recovery from substance dependence.

By the time sex addicts seek help, their marriage or relationship is often in great distress. Communication is lacking, and distrust, anger, and resentment are chronic. Couples counseling by a therapist who is knowledgeable about sex addiction can facilitate forgiveness and rebuilding of trust.[62] Such counseling is unlikely to be effective, however, as long as the signifi-

cant other persists in viewing himself or herself as the victim. The significant other should be encouraged to obtain individual therapy to deal with his or her probable dependence issues, fear of abandonment, external locus of control, and low self-esteem. Attendance at 12-step programs for partners of sex addicts can facilitate recovery.

Community and National Resources

TWELVE-STEP PROGRAMS

The 12 steps of AA have been adapted for use in programs for sexual disorders. Programs modeled after Al-Anon (the mutual-help program for families and friends of alcoholics) are also available in many cities. Group support can be a powerful tool for overcoming the shame that most sex addicts and their family members feel. Table 48–7 provides addresses of the national offices of the 12-step programs. These offices can provide information about meeting locations as well as literature about the addiction.

Because the goal in recovery from addictive sexual disorders is abstinence only from the addictive behaviors, the definition of *sexual sobriety* has room for interpretation. The various 12-step programs listed in Table 48–7 differ primarily in their definition of sexual sobriety. For Sexaholics Anonymous, it is limited to sex within marriage. In the other programs, members define their own recovery plans and determine which behaviors to avoid. The members of Sexual Compulsives Anonymous are primarily gay men and lesbians. The two recovery programs for family members have no significant differences. Recovering Couples Anonymous is a program for couples recovering from all addictions; approximately 50% of the members are recovering from addictive sexual disorders.

OTHER RESOURCES

Professionals seeking additional information on addictive sexual disorders can contact the National Council on Sexual Addiction and Compulsivity, located at P.O. Box 16104, Atlanta, GA 30321-9998. Their help-line telephone number is (770) 968-5002. This organization has an annual educational conference, sponsors a refereed journal, *Sexual Addiction and Compulsivity,* and publishes a quarterly newsletter.

Patients seeking information for themselves and family members can be referred to the books for laypeople by Carnes,[7] Earle and Crow,[63] Kasl,[41] Schneider,[32] and Schneider and Schneider.[22]

The Interfaith Sexual Trauma Institute (ISTI), located at Saint John's University, Collegeville, MN 56321 ([612] 363-3931), affirms the goodness of human sexuality and advocates respectful relationships through appropriate use of power within communities of all religious traditions. ISTI promotes prevention of sexual abuse, exploitation, and harassment through research, education, and publication. In areas of sexuality, ISTI offers leadership, gives voice, and facilitates healing of victims, communities of faith, and offenders, as well as those who care for them.

The Walk-In Counseling Center, 2421 Chi-

Table 48–7. TWELVE-STEP PROGRAMS FOR SEX ADDICTION

For the Addict

Sexaholics Anonymous
P.O. Box 111910
Nashville, TN 37222-1910
(615) 331-6901

Sex Addicts Anonymous
P.O. Box 70949
Houston, TX 77270
(713) 869-4902

Sex and Love Addicts Anonymous
P.O. Box 119, New Town Branch
Boston, MA 02258
(617) 332-1845

Sexual Compulsives Anonymous
Old Chelsea Station
P.O. Box 1585
New York, NY 10013-0935
(800) 977-HEAL

For the Partner

S-Anon
P.O. Box 111242
Nashville, TN 37222-1242
(615) 833-3152

Codependents of Sex Addicts
P.O. Box 14537
Minneapolis, MN 55414
(612) 537-6904

Co-SLAA
P.O. Box 1449
Brookline, MA 02146

For Couples

Recovering Couples Anonymous
P.O. Box 11872
St. Louis, MO 63105
(314) 830-2600

cago Avenue South, Minneapolis, MN 55404 ([612] 870-0565), is nationally recognized as a leader in providing resources and counseling to those who have been victims of professional sexual exploitation. The center is also known for its expertise in approaching, intervening in, and recommending evaluation for sexually exploitive professionals.

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