

Sexual Compulsivity & Its Therapeutic Treatment

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Sexual compulsivity is defined as the inability to control one's sexual behavior as evidenced by repetitive engagement in sexual activities despite their negative consequences (Carnes, 2001). As one of many types of compulsions, sexual compulsivity is a behavioral disorder that satisfies a short-term craving, and persists despite its long-term negative consequences (Mate, 2010)

If left untreated, sexual compulsivity can take over an individual's life. Sexually compulsive people can and do make sex a priority more important than family, friends, and work. Eventually, over time sex becomes the organizing principle of these peoples' lives. As a result, they are often willing to sacrifice what they cherish most in order to preserve and continue their unhealthy behavior.

This article presents an overview of sexual compulsivity including its various types, its etiology, its neurochemistry, its disclosure, and its treatment. The treatment portion of this article focuses on a number of therapeutic protocols in the literature that have been identified with successful recovery.

Types of Sexual Compulsivity

Sexual compulsivity involves a wide variety of behaviors, and when these behaviors become habitual, they become increasingly unmanageable. The most common manifestations of this type of out-of-control sexual behavior are habitual masturbation, extramarital relationships, pornography, cybersex, prostitution, and paraphilia.

Paraphilia is a type of sexual disorder characterized by persistent and repetitive sexually arousing fantasies and behaviors that are associated either with the use of nonhuman objects for sexual satisfaction (e.g., fetishism), the use of real or simulated suffering and humiliation (e.g., sadomasochism), or sexual activity with non-consenting parties (e.g., obscene phone calls) (American Psychiatric Association, 2000). The type of paraphilia that is abusive and illegal, such as obscene phone calls and exhibitionism, is often referred to as "noxious" paraphilia (McCarthy, 2003).

Another type of sexual disorder that involves sexually compulsive behavior, but does not involve illegal or abusive behavior, is known as compulsive variant arousal (McCarthy, 2005). Compulsive variant arousal is a habitual preoccupation and ritualization of sexual behavior that that serves as a substitute for intimate and interactive sex. It typically involves fetishism, masturbating to pornography, engaging in cybersex, and having impersonal sex with strangers (McCarthy, 2003).

Variant arousal is a very powerful compulsive pattern. For example, early in a marriage a partner might be sexually active in the relationship, but over time he or she becomes increasingly inactive and gets caught up in the narrow confines of variant arousal. Rather than feeling involved and turned-on during partner sex, the compulsive partner tries to focus on variant fantasies and activities. While most men and women use fantasies as a bridge to sexual

desire and arousal, variant fantasies and behaviors serve as a type of distancing phenomena from their partners. In reality, the other partner cannot compete with this distorted fantasy and secret world. Individuals with this pattern of arousal gradually become disconnected both emotionally and sexually from their partners (McCarthy, 2003).

Etiology & Neurochemistry of Sexual Compulsivity

Individuals who become sexually compulsive typically have well known profiles. The first profile, and increasingly the most common one for sex addicts, is that these individuals have been extensively exposed to intensive sexual experiences in the digital media. Three decades ago experts in human sexuality believed that arousal patterns were well established by early adolescence (Crooks & Baur, 1987). Today, as Carnes and Carnes (2010) point out, it is common for sex addicts to describe obsessive preoccupation with sexual behaviors they were not even familiar with until their use of digital media.

The reason for this unusual development is that the brain has the extraordinary ability to rewrite its synapses in the pursuit of sexual pleasure and is able to promote the continual need for self-administration of these sexual experiences. The digital production of multiple stimuli clearly intensifies that adaptation implicit in synaptic rewiring. As a result, these individuals report feeling intensely sexual an inordinate amount of the time at a level they had not experienced prior to using digital media (Carnes & Carnes, 2010).

The second profile, and by far the most common one for sexual compulsivity, is more developmental in nature. This profile involves the growing up experiences of these individuals. Most individuals who are sexually compulsive have backgrounds where they experienced any one or a combination of the following circumstances: they grew up in disturbed family settings, they experienced childhood abuse, they had other compulsive problems, and/or they had other family members who were compulsive (Carnes, 1991). As Mate (2010) concludes, early childhood and family difficulties are usually at the center of compulsive behaviors. He points out that the effects of early stress or adverse experiences shape both the psychology and the neurobiology of compulsivity in the brain. In effect, these early stressors eventually lead to distortions in the thinking and malfunctions in the neurochemistry of the brain.

In the brains of sexually compulsive individuals, the production and uptake of chemical messengers like endorphins and neurotransmitters like dopamine are often malfunctioning, and the compulsive behavior tends to provide them with a short-term correction that allows them to feel better. This is especially the case for sexual compulsivity where the human brain is wired to seek out this form of intense stimulation. For example, the human brain recognizes sex cues 20% faster than any other stimulus presented to it (Anokhin et al., 2006). Sex like food is differentiated from other compulsions because sex is wired in the brain for survival and is designed to be activated by the senses (Carnes & Carnes, 2010). As a result, sexual compulsivity is particularly challenging to overcome because of this in-built wiring and neurochemistry.

Another significant component in this brain chemistry is the fear of being exposed, whether it comes from earlier traumatic history or adolescent risk taking. In this context, fear of being exposed becomes a major neurochemical catalyst in the brain that releases various

hormones which further enhance the reward centers in the brain. So where fear would normally act as an inhibitor to manage sexual behavior, in this situation it serves as an accelerator that actually intensifies sexual compulsivity. At the same time, this phenomenon of fear also promotes a well-organized set of psychological defenses that help rationalize and minimize this behavior (Carnes & Carnes, 2010).

Regardless of what circumstances apply, both of the above profiles together present an overview of what factors make individuals vulnerable to sexual compulsivity. While each set of factors can in and of themselves lead to sexual compulsivity, the second set typically can and does lay the groundwork for increased vulnerability to the first set. In other words, those individuals who have painful growing up experiences and who have been exposed to chronic addictive behavior are much more susceptible to remediating their pain through compulsive behavior—including compulsive sexual behavior. Hence, these individuals are much more likely to get caught up in the virtual sex of digital media as a way of self-soothing their anxieties and insecurities.

Partners of Sexually Compulsive Mates

Sexual compulsivity is often shrouded in secrecy and shame. Most sexually compulsive individuals will go to great lengths to conceal their sexual behaviors—creating a world of confusion and pain for their partners. Because of these complications, it is common for the non-compulsive partner to bring the couple's problems to the attention of a therapist.

As Carnes and Carnes (2010) point out, partners of sexually compulsive mates fall into two categories: those who know about the compulsive sexual behaviors and those who don't. The partners who know about the compulsions typically don't know about the extent of their behavior, and sometimes may have even minimized or rationalized their behavior (e.g., believing men can't control their sexual urges).

The unknowing partners usually learn about the full scale of the compulsivity through a staggered disclosure process. This process usually begins with a discovery of cybersex or pornography on a computer device. Impulsive partners typically respond to this discovery in the following ways: (1) denying everything, (2) disclosing what they think they can get away with, (3) revealing more, (4) becoming more forthright as more information is discovered, and finally (5) disclosing the full extent of their sexual compulsivity (Carnes & Carnes, 2010).

This elongated disclosure process can unfold over years and can be repeated many times. This has the effect of severely eroding trust in the relationship and is usually very disorienting for the betrayed partner. Research has shown that some of these partners can actually experience trauma symptoms (Steffens & Rennie, 2006). These partners typically need to experience honesty and accountability on the part of the sexually compulsive partners so that they can be empowered with the truth and develop enough trust to continue in their intimate relationship (Carnes & Carnes, 2010).

Treatment Protocols

Once a problem of sexual compulsivity has been identified, there are a number of treatment protocols that have been identified as critical conditions for successful recovery. Experts in the field of treating sexual compulsivity have emphasized the importance of individual, group, and therapy as key clinical elements in leading to successful recovery (Carnes, 2001; Schneider, 1990; Earle & Crow, 1998).

Individual Therapy

In regard to individual therapy, Carnes (2001) has identified key tasks which can be integrated into early treatment. These include: (1) breaking through denial, (2) learning about sexually compulsive behavior, (3) surrendering to the process of recovery, (4) limiting damage from acting-out behavior, (5) establishing sobriety, (6) ensuring psychological health and well-being, and (7) participating in a culture of support and accountability. These are not necessarily sequential, and most people seeking recovery will begin working on several of these simultaneously during the initial phases of treatment.

Establishing sobriety early on in treatment is a critical—yet often difficult—task. One helpful tool for maintaining sobriety is a Sexual Sobriety Contract. Through this tool, behaviors can be broken down into “red light” (off limits because they constitute relapse), yellow light (off limits because they threaten or bring the person close to relapse), and “green light” (important to do) categories. This detailed plan of action can be shared with their partners as part of the overall process of restoring relational trust. In developing this plan, the therapist can help recovering partners recognize the people, places, emotional states, relational dynamics that trigger compulsive reactions which need to be avoided or effectively managed. For instance, if the primary form of acting out is the Internet, computer usage can be limited to certain times or places, and filters and monitoring software can be installed (Orzack & Ross, 2000).

Helping recovering clients disclose all their sexual acting out behaviors, as well as going over a complete history of their sexual socialization, are important tasks in early treatment (Earle & Crow, 1998). As the therapist actively listens to their story, questions are asked to determine key moments in their development and/or escalation of the compulsive patterns of sexual behavior. Furthermore, this process helps clarify what still needs to be shared with the partners of recovering clients. It is also important to note that those who victimize others often have a history of being victimized themselves (Murry, 1991). While focusing on victimization in no way justifies the offending behaviors of recovering clients, it does point to the need for them to work through their previous personal neglect and abuse.

Indeed, unresolved anger/resentment and shame (a sense of being fundamentally flawed) often accompany childhood neglect or abuse, and are two common fuels for compulsive sexual behavior. As a result of therapy, clients can move from resentment and/or shame about having been abused, to appropriate guilt and apology work for their own abusive sexual behavior(s). This healing process helps these individuals not only stop their destructive behaviors, but to experience a genuine sense of well-being versus the fleeting pleasure of acting out. Such a

transition may often require helping these individuals access, express, and resolve their unresolved emotions that have been repressed for many years.

Group Work

Group work often takes place in conjunction with individual therapy. This kind of treatment can provide recovering clients with further insight, support, and accountability. Through group work, recovering clients can break through their denial, can develop more emotional honesty, and can form relationships which transcend the ethical limitations of the therapist-client relationship. For example, recovering clients often report that one of the most helpful “green light” behaviors is to call a peer from the group when triggered or slipping into a compulsive cycle.

Options for group work include therapist-led groups and self-help groups. Therapist-led groups, when available, can provide an organized structure and consistency that are particularly important in early treatment. Self-help groups, which are widely available, consist mostly of 12-step oriented groups like Sexaholics Anonymous, Sex Addicts Anonymous, etc. Within these 12-step groups, it is common to seek out a “sponsor” with whom recovering clients can successfully complete their 12-steps and check-in regarding their sobriety. Such groups can also provide the added benefit of increased flexibility (more groups per week, different hours, locations, etc.) at no financial cost.

Couple Therapy

When recovering clients are in committed relationships, involving their partners is another important part of treatment. Initially, many partners may fail to see the need to be involved, or fear that their partners have convinced the therapist that they are actually the ones to blame. However, most relationship-oriented therapists are well aware of this concern and keep recovering partners focused on taking responsibility for their own bad choices and compulsive habits.

Initial work with these couples largely focuses on helping them recover from the ordeal they have been through as well as assisting them to re-establish a modicum of open communication and caring behavior in their relationship. Ultimately, patterns of sexual dysfunction and destructive coping behavior also have to be addressed in order for their relationship to move forward (Schneider, 1990).

Partners of sexually compulsive mates often have their own compulsive behaviors and cognitive distortions which frequently escalate within the context of their relationship. These can include obsessive working, detective work, enabling, ignoring their own needs, making excuses for their partner, and/or trying to control their partner's compulsive behavior (Earle & Crow, 1998; Schneider, 1990). This interconnected dynamic involving both the so-called "identified patient" and the other partner (often referred to as co-dependent) often leads to enmeshed dynamics and/or heightened reactivity within the relationship, creating fertile ground for acting-out behaviors by both partners. A skilled relationship-oriented therapist can help the couple recognize when they are caught in this interaction pattern and identify healthier

alternatives. Indeed, balancing support and challenge of the other partner is a difficult yet critical task. Directing the other partner to relevant readings and/or referring the other partner to support groups, such as Co-Dependents of Sex Addicts (COSA), can often be beneficial as well.

Regarding disclosure, most people who are with sexually compulsive partners have found out about their destructive behaviors through discovery rather than through honest sharing. Many of these partners have learned to be excellent detectives in an attempt to make sense of the craziness which inevitably surrounds them. For this reason, a critical goal of couple therapy is obtaining open disclosure where the sexually compulsive partner learns to share everything deemed necessary for the couple to move forward in a more positive direction.

When infidelity has taken place as part of sexual compulsivity, most partners will need both direction and motivation from the couple therapist to stay on a path that will ultimately lead to restoration of relational trust (Glass, 2001; Spring, 1997). When both partners express a desire for remaining together, a process of interpersonal reconciliation can be particularly helpful (Case, 2005). Interpersonal reconciliation involves a multi-step process in which each partner focuses on key tasks involving thoughts, feelings, and behaviors pertinent to recovering from infidelity (Worthington & DiBlasio, 1990).

As part of this reconciliation process, the offending partner concentrates initially on apology work including:

- Making a full disclosure of the sexual behavior that took place, and if sexual contact was made with other persons, specifying what protection was or was not used;
- Acknowledging completely the hurtful behavior(s) that took place;
- Developing understanding and empathy on the impact the compulsive behavior had on the other partner;
- Learning how and why the behavior developed and identifying what issues need to be addressed/resolved;
- Developing a detailed plan of action to avoid repeating the hurtful behavior;
- Sharing this plan with the other partner and faithfully following through with it; and
- Providing a sincere apology and asking for the opportunity to restore trust.

Following his or her partner's lead, the betrayed party focuses on a process of understanding and exoneration including:

- Acknowledging the injustices and their impact;
- Honestly expressing and working through feelings of hurt and anger;
- Learning to recognize "red flags" and set needed boundaries for self-protection;
- Shifting from judgment of the person to judgment of the behavior;
- Recognizing one's own hurtful behaviors in the relationship;
- Ceasing to punish the other person out of revenge or efforts to control the other partner;
- Eventually choosing to resume interactions that promote intimacy in the relationship

By providing this detailed roadmap, the therapist can help the couple understand that healing is possible but requires work in several areas over time. Initial sessions often focus on assisting the couple understand the need to work through painful emotions, rather than avoiding them through premature expressions of forgiveness (Hargrave, 1994). As the process unfolds, it

can be helpful to have each partner write an ongoing letter encapsulating their experience as they do their apology and reconciliation work. Sharing the letters toward the end of their therapeutic journey can also provide a powerful shift into what, for many couples, becomes a more honest and loving relationship than they had ever imagined.

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