

Treating Sexual Compulsivity

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Sexual compulsivity is defined as the inability to control one's sexual behavior as evidenced by continuing engagement in this behavior despite its negative consequences and the desire to stop it (Carnes, 2001). If left untreated, sexual compulsivity can come to dominate an individual's life completely. 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.

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 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 (Cintron & McCarthy, 2005). Compulsive variant arousal is a habitual preoccupation with sexual activities that serve as a substitute for intimate and interactive sex. It typically involves fetishism, cross-dressing, masturbating to pornography, engaging in cybersex, and having impersonal sex with strangers (McCarthy, 2003).

Variant arousal can be quite damaging to intimate relationships. For example, early in a marriage a man might be sexually active in the relationship, but over time he tends to become increasingly inactive and becomes trapped in the narrow confines of variant arousal. Rather than feeling involved and turned on during partner sex, the man 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 become an end in themselves and serve as a type of distancing phenomena from partner intimacy and sexuality (McCarthy, 2003).

This pattern usually develops in childhood or early adolescence and is reinforced by thousands of experiences of masturbating to images of variant arousal. It is best thought of as a kind of addictive behavior that serves as the man's "secret sexual world." He most often distorts the situation by thinking it's okay because it involves his own private life and it does no harm to others. In reality, couple sex cannot compete with this

distorted fantasy and secret world. As a result, individuals with this pattern of arousal gradually become disconnected both emotionally and sexually from their partners (McCarthy, 2003).

Treatment Protocols

Once a problem of sexual compulsivity has been identified, there are a number of treatment protocols that have been identified as critical to successful recovery. Experts in the field of treating sexual compulsivity have emphasized the importance of individual, couple, and group therapy as the 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) insuring 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 phase 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 one’s partner as part of the overall process of restoring relational trust. In developing this plan, the therapist can help the client recognize the people, places, emotional states, relational dynamics that trigger the client into compulsive reactions which need to be avoided or effectively managed. For instance, if one’s 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 used (Orzack & Ross, 2000).

Helping the recovering client report all sexual acting out behaviors, as well as going over a complete history of sexual socialization are important tasks in early treatment (Earle & Crow, 1998). As the therapist actively listens to the client’s story, questions are asked to determine key moments in the development and/or escalation of the compulsive patterns of sexual behavior. Furthermore, this process helps clarify what still needs to be shared with the client's partner. It is also important to note that clients who victimize others often have a history of being victimized themselves (Murry, 1991; Carnes, 1983). While focusing on the client's own victimization in no way justifies the his or her offending behavior, it does point to the importance of working through previous personal abuse and neglect.

Indeed, unresolved anger/resentment and shame (a sense of being fundamentally flawed) often accompany childhood abuse or neglect, 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 about their own abusive sexual behavior(s). This healing process helps the client to not only stop destructive behaviors, but to experience a sense of real happiness versus the fleeting pleasure of acting out. Such a transition may often require helping the client access, express, and resolve emotions which have been repressed for many years.

Group Work

Group work can provide the recovering client insight, support, and accountability. Through group work, the recovering client 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, clients report that one of the most helpful “green light” behaviors is to call a peer from the group when triggered or slipping into the compulsive cycle.

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

Couple Therapy

When the client is in a committed relationship, involving the client's partner is an important part of recovery. Initially, a partner may fail to see the need to be involved, or fear that the client has now convinced the therapist that he or she is to blame. A well informed and relationship oriented therapist can help clarify the possible benefits of such involvement. Initial work with the couple will largely consist of helping the partners work through the trauma they have been through. Ultimately, any sexual dysfunction or destructive coping patterns will have to be addressed and resolved in order for the relationship to heal.

Partners of individuals with sexual compulsivity problems often have their own compulsive behaviors and cognitive distortions which frequently escalate within the context of the 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 his partner (often referred to as co-dependent) often leads to enmeshment and/or heightened reactivity within the relationship, creating fertile ground for acting-out behaviors by both partners. Furthermore, a trained 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. Referring the partner to support groups such as Co-Dependents of Sex Addicts (COSA) or recommending materials may prove beneficial.

Regarding disclosure, most people who are with sexually compulsive partners have found out about their destructive behaviors through discovery rather than through honest sharing. Thus, they 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 positive direction.

When infidelity has taken place as part of the compulsive sexual behavior, most partners will need both direction and motivation from the 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 the 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; and

- 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 specific areas over time. Initial sessions can focus on assisting them 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 on going letter as they do their apology and reconciliation work. Sharing the letters at the end of their healing journey can provide a powerful shift into what for many couples proves to be a better relationship than they ever imagined.

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