Individual Psychology, Cognitive Behavioral Therapy, and Betrayal Behavior in Relationships

A Literature Review

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Abstract

The effects of sexual addiction can be extremely traumatic and have detrimental relationship outcomes due to betrayal behavior. Due to the severity of betrayal effects, the mental health of the individual and his or her partner may suffer and warrant participation in therapy to assist with the healing process. The purpose of this literature review is to examine the effects of sexual addiction and betrayal behaviors in couple relationships. In addition, the suggested integration of cognitive behavioral therapy (CBT) and Individual Psychology techniques could to reduce betrayal behavior and increase the potential for lasting couple relationships.

Keywords: sexual addiction, betrayal behavior, CBT, Individual Psychology
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Dedication

I would like to dedicate this paper to my oldest brother and sibling Tim Ward: He was a source of inspiration because of his extremely kind heart and his hard-working and driven attitude. He passed away in his sleep on May 26th, 2017, and I will forever be heart-broken because of it. I know he was proud of me, and I wish he could have seen me complete my degree. I would also like to dedicate this paper to my sister Angie Ward, she suffered a stroke on July 9th, 2017, and is still in recovery over two months later. She still checks in with me to see how the paper is coming along. She has always supported and encouraged me, despite what she is currently going through.
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It felt like there was another woman or a "something" there that was competing for his attention. I felt like he was choosing between me and "it," and "it" usually won. I felt that I should have been first in his heart, but "it" was. I guess that I was a coaddict, as I considered sex and love as the same, and when he was choosing the computer, he was rejecting me. When I was home nights, and he would finally come to bed, then say he was too tired, I would try to interest him, and when I was unsuccessful, I would go into the living room and cry for hours. He said that the computer was only a small part of the sex addiction, that pornography and meeting other people was a greater part, but the computer was an object that I could see, and, I guess, hate. When he was away from home, he could make up excuses for what he was doing, but when he was sitting in front of the computer and conversing for hours, there was no doubt what he was doing. The kids knew what was going on, to an extent. My son says there is no way that he can trust his dad, but my son also has been visiting porn sites, until we found out and talked to him about it. I resented the computer for years, until I finally accepted the fact that it was the user, not the machine that was causing the problem. (Schneider, 2000, p. 32)

41-year-old woman, married 23 years

I knew my husband was masturbating all the time, but I thought it was my fault. When I found the computer disk going back five years, everything made sense. I had been in denial about how much I knew, and how much my life was out of control. I feel very used and violated because of this behavior, and I have lost my trust.
My husband would blame me when I would catch him masturbating at the computer. He would not do any chores when I was out; when I returned, he would throw the blinds and turn off the light really fast. He would keep looking at his pants to see if I could tell he had an erection. He would run out of the bedroom like he was just changing. He would call me and say he was coming right home at 4:00, and not show up until 7:00. He would say he was working really hard and not to give him a hard time. I knew he would be masturbating if I left the house. I never said no to sex unless he was wasted drunk, I was not feeling well, or I was working. I believed that if I had sex more often, or if I were better at sex, he would not masturbate as much. I surveyed my friends to see if they'd caught their husbands masturbating, to see how often they thought it was normal to masturbate, to see what kind of sex they had with their husbands and how often. I thought I was not good enough because I did not look like the girls in the pictures. I thought that if I dressed and looked good it would keep him interested. I would give up competing with his masturbating and not want to have sex with him. I would not walk into the room at night because I did not want to walk in on him. If the kids and I were coming home from somewhere and his car was there, I would run into the house first and be loud so the kids would not walk in on him. I found semen on my office chair and pubic hair on my mouse. I would get dressed fast so I would not have to have sex with him. I stopped making dinner because I would not know when he would be coming home. I would have to mentally prepare myself for sex. I tried to talk with him about masturbation and how often he wanted to have sex. I was in denial about how unhappy I was. My husband does not believe he has an addiction. He doesn't think it's a big deal because he says he was never with anyone else. He thinks all he needs is a more loving wife. (Schneider, 2000, p. 33)
When I know that my husband has masturbated to cyberporn, I don’t want him to touch me. I feel like I am leftovers, not first-run as I should be. My self-esteem is damaged beyond belief. To be honest, our sex life is pretty incredible—we are not prudes by any means. I just don’t understand. How can it be sooo good for both of us but still not enough for him? (Schneider, 2000, p. 33)

Despite years of research, models, and the extensive cost of sexual addictions in the United States, sexual addiction remains an unrecognized diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (Phillips, Hajela, & Hilton, 2015). Sexual addictions can include a variety of different activities including excessive activity or use of pornography or masturbation. Sexual addictions lead to significant betrayal behavior and cause extreme difficulties within committed relationships, within the addicted individual, and within the partner of the addicted individual (Phillips et al., 2015). Substance and gambling addictions have very similar definitions and symptoms of hypersexual disorders (Kor, Fogel, Reid, & Potenza, 2013).

Currently, when people struggle with sexually addictive behavior, they may participate in individual or group therapy and 12-step programs to alleviate distressing symptoms and behaviors related to the addiction. In the recommended therapeutic practice, therapists are encouraged to use an Adlerian approach to assist couples in the healing process after betrayal behavior. Therapists can use Individual Psychology techniques (Ansbacher & Ansbacher, 1956) such as: examining the client’s lifestyle, life tasks, and early recollections. In addition, therapists can combine Adlerian concepts and techniques with cognitive behavioral therapy (CBT). The combination of Individual Psychology and CBT could potentially facilitate the reduction of the
negative effects of betrayal behavior due to sexual addictions and heal the couple’s relationship (Hall, 2011).

**Sexual Addiction**

Phillips et al. (2015) stated the cost of addiction in the United States is two times that of any other disease of the brain, including Parkinson’s, Alzheimer’s, and other brain-related disorders. Regardless of years of research, writing, and development of research models pertaining to sexual addiction, an intense opposition to accept sex as an addiction continues within the medical field. Currently, sexual addictions are not specified as a disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013); however, Kor et al. (2013) believed there should be a diagnosis for sexual addiction. Kor et al. suggested sexual addiction could be considered *hypersexual disorder* followed by specifications as to the sexually addictive preferences.

Kor et al. (2013) stated similar to substance use disorders and pathological gambling, individuals with sexual addictions experience significant marital, occupational, and financial difficulties, particularly in relation to sexual urges and behaviors. For instance, difficulties in developing healthy attachments among romantic partners has been associated with hypersexuality. Kor et al. stated the most common reported behaviors are masturbation, compulsive use of pornography, compulsive cruising, and multiple sexual relationships. According to Garcia and Thibaut (2010), “Sexual addiction appears to include the core elements of behavioral addiction proposed by Potenza et al. a craving state prior to behavioral engagement, or a compulsive engagement; impaired control over behavioral engagement; and continued behavioral engagement despite adverse consequences” (p. 256).
Grohol (2016) stated in 2010, the American Psychiatric Association released a draft of preliminary criteria that defined sex addiction (formally referred to as hypersexual disorder). According to the draft criteria, hypersexual disorder would be diagnosed in adults 18 years or older. The symptoms of hypersexual disorder would include: recurrent and intense sexual fantasies, sexual urges, and sexual behavior for a period of at least six months. The sexual behavior would need to include at least four of the following symptoms: excessive time spent on sexual fantasies and urges, plans to engage in sexual behavior, repetitive engagement in the sexual urges, fantasies, and behavior in response to negative mood states (e.g., anxiety, depression, boredom, or irritability), repetitive engagement in the sexual fantasies, urges, and behavior in response to stressful life events, repetitive but unsuccessful efforts to control, or significantly reduce these fantasies, urges, and behaviors. Grohol suggested that the symptoms continue with repetitive sexual behavior and a disregard for potential physical or emotional harm to self or others. Physical or emotional harm could include clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of sexual fantasies, urges, and behaviors. Finally, the sexual fantasies, urges, and behaviors would not be due to direct physiological effects of drugs, medications, or manic episodes. A sexual addiction diagnosis would then be specified regarding the focus on masturbation, pornography, sexual behavior with consenting adults, cybersex, telephone sex, strip clubs, or other.

Similar to Grohol (2016), Voon et al. (2014) stated the term compulsive sexual behavior referred to excessive or problematic engagement in sex and may also be called hypersexual disorder or sexual addiction. Compulsive sexual behavior is a fairly common quantifiable behavior that may carry significant mental and physical health consequences. Voon et al. posited
that consequences associated with compulsive sexual behavior may include substantial emotional and physical distress, feelings of shame, and psychological dysfunction. Voon et al. believed that additional examination and research regarding compulsive sexual behavior was warranted because of the distress associated with the behaviors.

Grohol (2016) stated frequently, one sexually addictive behavior leads to another. One person may start with visiting strip clubs in excess, but then he or she may begin to have sex with some of the individuals at the club. This is due to the need for an increased amount of dopamine and higher tolerance related to the addiction. Reynaud, Karila, Blecha, and Benyamina (2010) stated continual sexual intercourse allowed individuals to experience “excess” pleasure and an uninhibited craving for this excess. Another example could be when a person begins with internet pornography and escalates to cybersex within chat rooms. In fact, the characteristics of sexually addictive behavior are similar to that of behavior related to chemical dependency and substance abuse (Garcia & Thibaut, 2010). Temptations and triggers stimulate a person with sexual addiction to act on sexual urges. *Triggers* inducing sexual urges may include: sadness and depression, happiness, loneliness, and shame (Schreiber, Grant, & Odlaug, 2012; Schreiber, Odlaug, & Grant, 2012). These urges and triggers observed in association with hypersexual behaviors are similar to those reported for substance use disorders and pathological gambling (Baker, Piper, McCarthy, Majeskie & Fiore, 2004; Edwards & Koob, 2010; Grant & Kim, 2002). Garcia and Thibaut (2010) stated when clients attempted to stop inappropriate sexual behaviors, they encountered intense feelings of dissatisfaction and depressing thoughts. These feelings are comparable to the withdrawal symptoms addicts experience when they suddenly quit using a drug. Once addicts begin to feel the negative symptoms from withdrawal, they are tempted to
engage in self-stimulating behaviors again (such as excessive masturbation) to escape the emotional overload.

When an individual is struggling with sexually addictive betrayal behavior, he or she may experience guilt, insatiable cravings, and increased irritability when attempting to refrain from the addictive material or actions (Park et al., 2016). In addition, men may experience additional sexual difficulties including erectile dysfunction, delayed ejaculation, decreased sexual satisfaction, and a diminished libido during sex with another individual. For example, Rosenberg, Carnes and O’Connor (2014) posited that, “Sex addicts feverishly pursue their dysfunctional sexual behaviors yet generally have sexual difficulties with intimate partners, healthy sexual encounters, and/or stable relationships” (p. 85).

Hall (2011) believed it is now clinically understood that the common denominator in all addictions is dopamine. Dopamine is the neurochemical responsible for the experience of reward and pleasure and is naturally stimulated by eating, drinking, and having sex. Hall stated that each individual may have personal reasons for pursuing these behaviors. For example, sexual behavior may become a means for the trauma sufferer to numb the feelings of hyper-arousal such as hyperactivity, obsessive thinking, rage, and panic. Additionally, sexual behavior may alleviate feelings of disassociation, numbness, depression, and exhaustion experienced in hypo-arousal (Hall, 2011).

**Pornography**

Pornography is defined as sexually explicit material including videos, photographs, writings, etc., created for the sole purpose of eliciting sexual arousal or stimulation (“Pornography,” n.d.). Physical contact may not be required to constitute a betrayal in a relationship (Phillips et al., 2015). Multiple hours of viewing online pornography could have the
same effect on intimate relationships as time spent with the magazines and videos. According to Phillips et al., *sexually explicit material* is considered anything that displays full or partial nudity of male or female genitalia or female breasts, sexual intercourse, or other sexual behaviors. Phillips et al. suggested sexual addictions contributed to the lucrative nature of pornographic materials. Adult magazines are readily available at different locations and the internet provides endless access to a large variety of free, explicit material. Schneider, Weiss, and Samenow (2012) suggested an additional challenge with newer technologies is that acts of infidelity have become easier to hide and deny. For example, unlike a computer browser, smart phone applications can be deleted with no visible trace or user activity history.

Hartman, Ho, Arbour, Hambley, and Lawson (2012) posited that although there are men and women willing to try new techniques in the bedroom, it is unlikely to include everything found on the internet. Individuals become increasingly aroused by the unending fantasy opportunities provided by pornographic material. As a result, a person may feel the need to increase the number of times he or she masturbates. Real life tasks and situations can have a tendency to get in the way of a person’s intimate life. Because of this, a person may gravitate toward the more accessible and explicit material instead of waiting for the opportune time to be with a partner. Park et al. (2016) suggested current internet pornography increased because individuals begin regular use of pornographic material at a younger age. This early age of regular viewing and use of pornography appeared to create a greater preference for the explicit material and less enjoyment from partnered sex.

**Masturbation**

Garcia and Thibaut (2010) stated various sexual addictions can greatly interfere with many areas of an individual’s life including work, school, and leisure activities. For instance,
people with excessive masturbating as a preferred form of sexual addiction could have difficulty refraining from masturbating at work, school, and home. The need and craving for the sensation of an orgasm is so strong for some individuals that if one cannot refrain from this particular activity, he or she may lose a job and potential income. Additionally, excessive masturbation can cause decreased sex drive and increased intimacy problems with a partner. Individuals may desire only the self-pleasure they accustomed to and do not obtain enjoyment in sexual intercourse with another person (Garcia & Thibaut, 2010).

**Sexual Addiction and Couples**

Reynaud et al. (2010) stated sexual addiction caused issues for both the addicted individual and the significant other in a committed relationship. For example, a severe lack of trust developed after several instances of betrayal in a committed relationship. Additionally, if the betrayal was discovered by the partner, and not by self-disclosure, then secrecy becomes another relationship problem. Rosenberg et al., (2014) stated both sex addicts and their partners may experience sexual anorexia, sexual aversions, impaired desire, anorgasmia, and/or sexual dysfunctions as a result of the sexual addiction. In addition, males may also experience premature ejaculation and erectile dysfunction.

Greef and Malherbe stated a vast array of feelings develop in a couple relationship with a sexually addicted partner (as cited in Yoo, Bartle-Haring, Day, & Gangamma 2014). The addicted individual’s partner may suffer feelings of jealousy, inadequacy, sadness, anger, and resentment toward their loved one. Once confronted, the addict typically responds with a defensive attitude, irritation, and internal feelings of shame, guilt, and embarrassment. As a result, individual concerns increase the relational conflict and create extensive concerns for the
couple such as intimacy issues and difficulty with the emotional and physical components of the relationship.

Intimacy refers to both emotional and physical feelings of closeness in relationships (Yoo et al., 2014). Schaefer and Olson stated, “The link between couple intimacy and overall relationship satisfaction is well established in current literature; couples tend to report high levels of relationship satisfaction when they have feelings of intimacy” (as cited in Yoo et al., 2014, p. 275). Negative relationship outcomes are expected when there is a failure to establish intimacy in a romantic relationship, and at times, this includes the dissolution of the relationship (Yoo et al., 2014).

When there is sexual addiction in a committed relationship, the quality of a couple’s sex life may decrease due to the negative feelings and the significant reduction in the addicted individual’s sex drive. In particular, the sex drive and desire for a physical person may decrease when a partner is addicted to pornography. According to Park et al. (2016), “Internet pornography is unique in that it has multiple formats (video or stills), endless novelties, and escalates to extreme material, these do not always transition to real-life partners and expectations are not met, thus causing arousal to decline” (p.1). Park et al. suggested that an addict’s partner noticed when he or she was no longer desirable, and sexually addicted clients experienced difficulty returning to an honest and committed relationship. Although suspicion and confrontation may precipitate disclosure when relationship distress is high, most addicts report that their partners do not know about extramarital behaviors or they disclose only what they believe the partner already knows. This lack of full disclosure perpetuates deceptiveness (Corley, Schneider, & Hook, 2012).
Secondary issues often follow dishonest behaviors (Pollard, Hook, Corley, & Schneider, 2014). Secondary issues for the non-addicted partner include: questioning all actions and behavior of the betrayer, doubting all conversations and convictions, and changing everything about him or herself to accommodate the partner’s perceived wants and desires. Pollard et al. suggested that the first reason addicted individuals seek treatment for addictive behavior is because of a loved one. The second reason would be because of the addict’s need to become a better person. Frequently, when sexually addicted people are involved with a partner, they must first better themselves before they can improve the status of the relationship. Overall, relationship complications, and a desire to save the relationship, are the driving forces behind seeking help and treatment. According to Woody (2011), couples had very difficult encounters when attempting to move forward and progress in the relationship if they could not move past the betrayal and begin to trust. As a result of this lack of trust, the relationship was stuck within the addiction and created a need for assistance from an outside source to help the couple continue to rebuild the relationship.

**Current Treatment**

It is possible that some individuals have an increased interest in sexual thoughts or activities when they struggle with depression or anxiety. According to Hartman et al., (2012), “Since sexual addiction often coexists with and shares similar biological processes and clinical symptoms with substance use disorders, the underlying framework for concurrent treatment may share similarities as well” (p. 291). Hartman et al. stated current treatment for individuals struggling with sexual addictions is based on the addiction model and is similar to substance use and substance abuse treatments. Current available treatment for sexual addiction includes individual therapy, 12-step programs, and group therapy.
**Individual Therapy**

Individual therapy, psychotherapy, or counseling is a process through which clients work one-on-one with a trained therapist (Chicago School of Professional Psychology, n.d.). The environment is caring, safe, and confidential. The purpose of individual therapy is to explore feelings, beliefs, and behaviors, or to work through difficult and challenging memories. The clients are able to discover what they want to change or better understand, and set goals to work toward that change. The aim of therapy is to assist clients in changing the lifestyle so they can move through life more effectively (Corey, 2009).

Komasi, Zakiei, Saeidi, and Moghani (2016) found that an individual’s thinking patterns, information processing style, and interpretations of events caused negative emotions and anxiety. According to Komasi et al., beliefs and feelings change when the mindset changes. Currently, (CBT) is one treatment modality that could be used in conjunction with individual therapy to address a client’s beliefs, feelings, and mindset.

**Cognitive Behavioral Therapy**

Cognitive behavioral therapy is a combination of both cognitive and behavioral values and techniques in a short-term treatment methodology (Corey, 2009). Cognitive behavioral therapies:

- are grounded in a structured psychoeducational model,
- emphasize the role of homework,
- have an expectation of active participation in and out of therapy, and
- determine a variety of behavioral and cognitive strategies to facilitate change (Corey, 2009).
Cognitive behavioral therapy is based on the assumption that a restructuring of an individual’s self-declarations will result in a similar restructuring of an individual’s behavior (Corey, 2009). Corey found therapy can have a profound effect on behaviors, and behavior modifications can create a more desirable lifestyle.

Hall (2011) posited CBT practitioners would likely focus on the thoughts, feelings, and behaviors triggered by sex addiction. Exploring impulse control, triggers, urges, and negative thinking patterns can initiate behavior change and improve coping mechanisms. Additionally, it is well known and recognized within CBT that all addictions, both chemical and process, are used as a form of affect regulation. There is, of course, nothing wrong with using sex, or alcohol, depending on your viewpoint, to alleviate difficult emotions and to create a sense of well-being; however, if either one become a primary coping mechanism, in spite of negative consequences, then it could be considered an addiction and further complicate the life of the individual and the partner (Hall, 2011).

Fuller and Taylor (2010) suggested that the exploration of impulse control, triggers, urges, and negative thinking patterns could initiate coping mechanisms that facilitate behavior change. In addition, Fuller and Taylor found that motivational interviewing techniques (i.e., a respectful and soothing approach used to determine client goals, values, and current behaviors) may help facilitate permanent change.

Schema therapy, developed by Young, Klosko, and Weishaar (2003) is relatively new to cognitive therapy. Schemas are stable, enduring, negative patterns of beliefs and feelings about oneself that develop during childhood or adolescence and are expanded, usually without awareness, throughout an individual’s life. By bringing schemas into conscious awareness,
therapists can assist the client in re-writing the script to enable conscious choices about how the client would like to feel, think, and behave in the world (Young et al., 2003).

**Twelve-Step Programs in Group Therapy**

Experts (2017) stated twelve-step support groups were created to help people overcome unhealthy dependence on behaviors causing distress in life. Twelve-step support groups are based entirely on the twelve-step program created for alcoholics. The support groups follow the addictions model construct and replace alcohol or substance addiction with sexual addiction. The support group emphasizes support and structure rather than material or monetary benefits.

Hartman et al., (2012) suggested,

Group therapy (including 12-step groups) is important as individuals with sexual addiction struggle with interpersonal relationships and feelings of shame; it is such relationships that help individuals in their recovery by providing support, structure, and accountability (Goodman, 1993; Schneider & Irons, 2001). Thus, group settings can provide an opportunity for individuals with sexual addiction to develop interpersonal skills, gain a sense of belonging, form healthy non-sexual relationships, and allow the individual to realize they are not alone in their struggles. (p. 292)

The group therapy setting could be important for sexually addictive personalities because the struggle is within rather than with external substances (Hartman et al., 2012). As group members establish a sense of belonging, they could increase confidence to work through, and overcome, the problem. Group settings are different from individual therapy because members physically see other people struggle with similar problems. The group format has the potential to help people feel less like an outsider and regain a sense of hope. The addicted individual may have family and friends that could benefit from the group process (Pollard et al., 2014).
Pollard et al. (2014) found that some partners of sex addicts may define themselves as co-addicts or relationship addicts. Partners may participate in 12-step programs such as Sexaholics Anonymous (S-Anon) and Codependents of Sex Addicts. Pollard et al. stated group meetings for addicts and partners address issues such as restoring trust, forgiveness, softening discussions about problems, shifting attitudes, healthy sexuality, fair fighting, dealing with illness, improving communication, how to avoid monitoring the partner’s recovery, talking to children about the parent’s recovery program, financial negotiation, problem solving, and increased unity.

**Sex and love addicts anonymous (SLAA).** Herring (2016) stated, sex and love addiction is considered any sexual or emotional act, despite what the initial impulse is, which leads to loss of control over frequency, rate, or duration of its occurrence or recurrence, causing spiritual, mental, physical, emotional, and moral destruction of oneself and others. According to SLAA sobriety is self-restraint over one's self-identified "rock-bottom" behaviors (Herring, 2016).

**Sexaholics anonymous (SA).** Participants in Sexaholics Anonymous consider lust the primary source of addiction (Wright, 2010). It is different from most other groups because of the rigid guidelines. For example, sex or celibacy are the only options in a heterosexual marriage. If participants choose to be celibate, they completely refrain from all sexual activities—including self-pleasure.

**Sex addicts anonymous (SAA).** Members of SAA do not believe sex is the root cause of problems. Rather, the belief is that the addict is addicted to certain sexual behaviors (Herring, 2016). The goal of SAA is to assist the group members as they distinguish between addictive sexual behavior and healthy sexual behavior. Once this is determined, the therapeutic process would continue to help alleviate the negative (unhealthy) behaviors and increase the positive (healthy) behaviors.
Individual Psychology

In 1912, Alfred Adler developed a humanistic approach to Individual Psychology and was a prominent, leading figure in the humanistic movement (Mitchell, n.d.). Adler left Sigmund Freud’s Analytical Society due to the emphasis Freud placed on psychoanalysis. Several other members of Freud’s group followed Adler. Adler defined Individual Psychology as a modification of psychoanalysis that emphasized feelings of inferiority and a desire for power as the primary motivating forces in human behavior (Mitchell, n.d.).

According to Ansbacher (1974), Adler viewed his theory of psychology in terms of the relationship between an individual and the problems of life. That is, Adler moved beyond traditional psychological issues involving such things as memory, perception, thinking, feeling, and instincts. Dreikurs (1982), posited that Individual psychology was used to determine how an individual solves problems. For example, Adler wanted to know if problem solving was productive and positive, or damaging and negative. According to Miller and Dillman Taylor (2016), Adler believed that all behavior had purpose and meaning, although people may not always be aware of the purpose and meaning. Miller and Dillman Taylor stated Adler believed in purposeful behavior and the humanistic conception that human beings are intentional as they attempt to find value and meaning.

The Adlerian therapist’s job is to treat the client as an equal and uncover misguided actions and beliefs that lead to problematic events (Mitchell, n.d.). In addition, the therapist would serve as the client’s guide as he or she establishes a more useful way of life. Mitchell (n.d.) suggested that positivity and empowerment are possible when clients experience relief from painful symptoms (Carlson, Watts, & Maniaci, 2006). According to Ansbacher and Anbacher (1956), when clients are socially involved, they feel less inferior and obtain a greater
sense of belonging and security. In addition, belonging and security promote the healing process. The core Adlerian concepts addressed for the purpose of this project include: lifestyle, life tasks, and early recollections.

**Lifestyle**

According to Oberst and Stewart (2003) *lifestyle* can be described as perceptions regarding self, others, and the world. This perception would include thought patterns, actions, feelings, style of living, and how a person determines and assesses goals. According to Clark and Butler (2012), Adler stated an individual’s striving toward significance and belonging can be observed as a pattern. This pattern reveals itself early in life and can be observed as a theme throughout a person’s lifetime. According to Mosak and Maniaci (1999), Adler suggested that lifestyle was the key to how external data was analyzed, stored, and used. For instance, lifestyle dictated a person’s behavior in a given situation and was most clearly observed when a person faced life challenges such as stress, anxiety, and sadness (Mosak & Maniaci, 1999). Clark and Butler (1999) stated the individual’s lifestyle infiltrates all aspects of perception and action, and Adler believed that an understanding of emotional and mental process and organization could help a therapist understand clients. That is, if one understands an individual's lifestyle, behavior begins to make sense.

Mosak and Maniaci (1999) suggested that lifestyle is created by an individual’s core beliefs. As a result, lifestyle is the combination of various beliefs that develop from a person’s upbringing or childhood, and the lifestyle will influence an individual’s sense of belonging. According to Carlson et al. (2006), lifestyle consists of beliefs about “what is” and beliefs about “what should be.” The belief about “what is” can be further divided into the self-concept and the
worldview (or Weltbild). The belief about “what should be” can be further divided into the self-ideal and ethics.

Carlson et al. (2006) stated the self-concept is the combination of all beliefs regarding who “I am” and who “I am not.” In addition, the worldview includes beliefs about topics that would not be included in “the world is” or “people are.” These beliefs about “what is” are formed through experiences, based on reality, or by emulating guardians or caretakers. On the other hand, a person’s beliefs about what “should be” are not always based on reality. These self-ideal beliefs are the opposite of the self-concept and the worldview because they are not developed from modeling or direct experience, but are learned through a repetitive pattern of frustration with the world or the idealization of comments and actions from guardians.

Examples of self-ideal statements could include: “I should be strong,” “I should not be weak,” and “I should be independent.” Examples of ethical convictions could include: “People should be kind;” “Life should be fair;” and “It is wrong to hurt people.” Self-ideal statements and ethical convictions emphasize what “should be,” or ideals about the world and others, not about the self (Carlson et al., 2006); however, self-concept is developed from these beliefs. Examples of self-concept may include: “I am short;” or “I am dumb.” Examples of self-ideals created from those self-concepts could include: “I should be tall;” “I should not be dumb;” or “I should be smart.” These statements create core beliefs and contribute to an individual’s development and who they will become (Carlson et al., 2006). For example, core beliefs influence career choices, partner choices, hobbies, and addictions. In summary, lifestyle is composed of self-concept, self-ideal, worldview (Weltbild), and ethical convictions.

- Self-concept: Self-concept refers to personal beliefs and “I am” statements formed throughout life based on life experiences and observations. Self-concept is
typically developed when an individual assesses who they are against social surroundings. From this personal assessment individuals decide if they are inferior to others or if they are able to prosper and develop social interest (Griffith & Powers, 2007).

- Self-ideal: Self-ideal is the opposite of self-concept. Self-ideal is based on personal feelings of importance and “I should” statements. Self-ideal includes future thoughts and plans and can determine if a person will progress, regress, or stay the same. (Mosak & Maniacci, 1999).

- Worldview (Weltbild): The term Weltbild is translated as “world picture” and was used by Adler when he referenced the attitudes formed by people about the world. Worldview includes “people are” and “the world is” statements (Carlson et al., 2006).

- Ethical convictions: Ethical convictions supply directional movement based on inner beliefs regarding right and wrong and the ability to predict the consequences of behavior. Life experiences at school, work, and home contribute to the formation of ethical convictions (Carlson et al., 2006).

Life Tasks

Hawes and Blanchard (1993) stated Adler originally outlined three life tasks every individual must complete: social, work, and love. Later, the self and spiritual tasks were added to Adler’s original tasks of life. The life tasks play a significant role in a person’s life. For example, Adler believed the life tasks must be completed for an individual to feel a sense of internal fulfillment and purpose (Hawes & Blanchard, 1993).
The social task. The central belief of Individual Psychology is that happiness and success are largely related to social connectedness. Ansbacher (1992) stated the social life task refers to an individual’s sense of belonging in society. For instance, every individual has a need to cooperatively interact and socialize with other members of society. Ansbacher suggested that in spite of possible differences in opinion, humans can work together to feel wanted, essential, and needed. Ansbacher suggested genuine interest in the well-being of others contributes to an individual’s sense of belonging. Interest in others (social interest) has an impact on the development of beliefs regarding other areas of life. Maniacci (1991) stated Adler considered the extent of an individual’s involvement in social interest to be the foundation of mental health. Adler emphasized that healthy, adaptive functioning occurred within the community, not outside of it. Maniacci indicated the development of social interest can be challenging, but it is necessary for appropriate functioning within society and increased internal feelings of self-worth.

The work task. According to Hawes and Blanchard (1993), occupation is considered the most fundamental life task because it can contribute to a person’s feelings of worthiness, encouragement, and ability to contribute. In contrast, occupational status can make people feel equally worthless and discouraged. Without work, a person will not have money to provide for self or family. In addition, work increases an individual’s contribution to society and creates life balance (Hawes & Blanchard, 1993).

The love task. The love task includes fulfilling a role in an exclusive, committed relationship with another person (Hawes & Blanchard, 1993). Relationships include the ability to engage in the physical or sexual role to fulfill a partner’s physical needs and ensure the future of the human race. In addition, the non-physical component of the love task would include mutual open-communication, respect, and cooperation within an attitude of equality.
The self-task. According to Hawes and Blanchard (1993), Adler believed individuals could not fulfill the meaning of self until they fulfilled all other life tasks. For instance, Adler stated people cannot discover wants, needs, or true beliefs until they know more about other areas of life. To discover the true “self,” Adler found people must complete a journey of self-discovery to determine true desires and beliefs.

The spiritual task. The spiritual task refers to an individual’s relationship and connectedness to the rest of the world (Hawes & Blanchard, 1993). Connectedness incorporates the individual’s level of social interest, and social interest informs the spiritual life task. In addition, the spiritual life task includes the personal meaning and purpose for one’s existence. Once the spiritual life task is fulfilled, along with the other life tasks, a person can formulate a personal definition of the self and fulfill the last task of life.

Early Recollections

Clark (2013) stated when early recollections are used as a counseling technique, they can be an exceptional tool to identify a client’s distinctive perceptions of the self, other people, and life events. Additionally, the subjective meaning of early recollections is largely unknown to a person, therefore, the therapist may not see the response distortions commonly found in self-reports.

When the therapist engages the client in an early recollection, the client would thoroughly explain an earliest memory in the present tense (Clark, 2013; Clark & Butler, 2012). The client would then explain the feelings associated with the memory, the most vivid part of the memory, and how he or she felt about the self, world, men, and women. During the early recollection, the therapist would write the memory verbatim. The therapist would continue to explore earliest memories by collecting several early recollections. Next, the therapist would discuss the
recollections in great detail. After the early recollection process, the client and the therapist could explore the possible meanings and interpretations associated with the memories and complete a treatment plan suited to the client’s needs.

Clark (2013) suggested early recollections should be collected from every client to unveil hidden meanings regarding current beliefs surrounding the client’s life situation. The beliefs are used to depict and discern the actions and choices of every individual. Collecting early recollections during individual therapy sessions could yield pertinent information to facilitate increased control and management of sexual addictions and betrayal behaviors. While collecting the client’s information through the early recollection process, therapists could increase understanding regarding the origin of the behavior and recognize an established connection between past and current addictions. For example, early recollections could involve the earliest sexual memory or encounter (Hall, 2011). The therapist could increase the awareness of the client’s life tasks, present beliefs, and lifestyle.

Discussion

Hall (2011) suggested an Adlerian therapist could use early recollections to discover meaning associated with behavior, beliefs, and personal goals. Cognitive behavioral therapy includes many beneficial techniques designed to change behaviors (Hall, 2011). The proposed combination of Individual Psychology and cognitive behavioral therapy could be used to help couples resolve betrayal behavior associated with sexual addiction. Through an increased understanding of life patterns and life tasks, therapists can use the process of collecting early recollections to change behaviors and beliefs and increase marital satisfaction when one partner struggles with sexual addiction.
Implications for Practice

Frequently, an individual with any form of sexual addiction is attempting to alleviate the internal feelings they experience from an unresolved conflict encountered at some point in life (Hall, 2011). For instance, these internal emotions can stem from a traumatic experience, a subtle distressing experience, or from another mental health diagnoses such as depression or anxiety. Hall (2011) stated sex addiction may be used to avoid negative feelings such as boredom, depression, or anxiety. Hall found that sex addiction may be driven by a desire for intimacy and validation with others; however, once orgasm is achieved, those feelings can return with ten-fold intensity. Hall suggested that the underlying issue associated with sexual addiction is unresolved conflict. Early recollections (Clark, 2013) can be used in a proposed five-week individual therapeutic process with sexually addicted clients. The early recollection process could increase access to unresolved conflict and lead to the discovery of additional information.

**Week one.** The first week begins with information gathering regarding client concerns and relevant client history. In this session, the client completes necessary paperwork (e.g., confidentiality forms and informed consent forms). In addition to gathering information and completing paperwork, the therapist attempts to establish a meaningful therapeutic relationship. The therapist will work to develop trust and a sense of safety during this initial session.

**Week two.** During the second week of therapy, the therapist will obtain additional information, assess the client’s goals, and create a treatment plan with the client. This treatment plan would include early recollections. The early recollection technique will be used in conjunction with other therapeutic techniques including mindfulness exercises and coping strategies to prevent additional addictive or betrayal behavior. The therapist would incorporate CBT psychoeducational techniques to explain that the betrayal behaviors (i.e., sexually addictive
behaviors) are used to evade problems or alleviate uncomfortable internal feelings (Hall, 2011). The therapist will educate and inform the client regarding addictive behaviors and provide information regarding support networks for the client and the client’s significant other.

**Week three.** During the third week of individual therapy, the client will explain the problems associated with betrayal behavior and the impact of the behaviors in terms of life tasks. As the therapist receives a detailed account of the client’s situation and use of sexually addictive behaviors, the therapist may potentially begin to discover triggers and patterns of those behaviors. As the therapist assesses the client’s lifestyle, the therapist will include the CBT schema therapy (Young et al., 2003) to uncover negative patterns of beliefs and feelings about oneself. Similar to early recollections, CBT schema therapy may assist in the client’s development of self-awareness and understanding of reactive patterns initiated during childhood. In addition, early recollections are collected and reviewed during the session to generate deeper understanding of the client’s values and beliefs.

**Week four.** At the beginning of every session, the therapist will ask the client to discuss thoughts and feelings associated with the previous week. The client and therapist review new concerns and any sexually addictive behavior since the previous session. The client will be encouraged to discuss feelings, thoughts, beliefs, and personal schemas about the addictive behavior. As in previous sessions, the therapist will complete another early recollection and review for possible triggers and patterns.

**Week five.** In this final session, the client and the clinician discuss previous early recollections, current life tasks, lifestyle, and the client’s beliefs about the self and society. Essentially, the client and therapist engage in a brainstorming session to identify possible connections to the betrayal behavior. Together, client and therapist develop a plan for continued
treatment. The client’s early recollections may reveal hidden trauma the client may have endured and repressed to evade pain and suffering. Repressed memories may be a contributing factor in the client’s sexually addictive betrayal behavior. As a result of previous trauma or identified concerns, the client may be encouraged to attend support groups or to seek additional individual, couple, and family therapy. The psychoeducational component of CBT combined with the identification of addictive behaviors, schemas, values, patterns, and beliefs through early recollections could be the first step toward recovery and healing a committed couple relationship.

Early recollections can yield significant results when integrated into therapy and used to discover and evaluate common themes or possible meanings associated with sexual addiction behaviors. For instance, Griffee et al. (2014) suggested that an adult’s interest in sex, and the likelihood of engaging in risky sexual behaviors, increases if an individual’s first experience with partnered sex, or initial masturbation to pornography, begins during the early years of life. If individuals struggle with sexual addiction, the therapeutic use of early recollections can help to determine the possible source of the behavior. The earliest memories can have a great impact on a person’s life. As Clark and Butler (2012) noted, during early childhood, children form lasting opinions about life. Deep-rooted expectations contribute to the formation of a person’s future lifestyle and expressions of personality. Clark and Butler stated it was Adler’s position that an individual’s degree of activity is formed during early childhood and “…relates to an individual's pattern of initiative and engagement in the experiences and tasks of life” (p. 136).

Hartman et al. (2012) stated sexual addiction often begins at a younger age than substance use addictions. In fact, Hall found many individuals struggling with sexual addiction began using addictive substances to alleviate the pain or discomfort connected to sexual
behaviors. Substances can potentially be avoided; however, when people struggle with sexual addiction, the origin of the addiction exists within.

**Recommendations for Future Research**

Current research revealed an increased number of individuals are addicted to pornography (Garcia & Thibaut, 2010; Hall, 2011; Hartman et al., 2012). The increased number of sexual addicts may be due to the exposure of explicit material at a younger age. Extensive longitudinal studies could monitor boys and girls at approximately nine years of age through age 25. While this may be difficult to accomplish due to the young age and the sensitive nature of the topic, the information would be useful in the understanding of sexual addictions. Throughout the study, surveys, and oral interviews could be conducted to determine the following: initial age of sexual interest, age of initial use of pornographic material, and age of first sexual encounter. The research process could continue with an additional survey every 6 to 12 months with questions regarding sexual interest and activities. The key component of this research would be the level of exposure to sexually explicit material as well as the age of the initial exposure. An alternative to the suggested research would be to survey young adults regarding sexual interest and activity during younger years.

**Summary**

Couples and individuals who recognize they have a problem with sexual addiction, and seek treatment to address the addiction, have a chance to heal and maintain the relationship (Corley, Pollard, Hook, & Schneider, 2013). As with any addiction, it requires a valid and extensive effort to discontinue betrayal behavior. Much like substance abuse, couples will experience relapse and mistakes will happen; however, with therapeutic support, the addicted individual can change behavior patterns, schemas, and beliefs and work toward personal goals.
Corley et al. (2013) stated trust and honesty are essential to recovery. When therapists work with couples where there is a sexually addicted partner, therapists are encouraged to establish trust and facilitate honesty and trust between both partners. Therapists could incorporate cognitive behavioral therapy and Individual Psychology techniques such as lifestyle analysis, life tasks, and early recollections to facilitate a decrease in betrayal behaviors, rebuild trust, and establish healing in the couple relationship.
BETRAYAL BEHAVIOR

References


