Sexual Addiction and the Female Client

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

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October 2013
Abstract
This paper is an attempt to expose the reality of the problem of sexual addiction among women. Though often believed to be only a problem among men, more and more women are courageously coming forward for help with unwanted sexual behaviors. This paper will show the need for increased treatment understandings, and in particular the need for treatments for the sexually addicted female client, which are rooted in empirical research, using standardized testing methods to produce statistically significant outcome data.

This paper will review the history of society’s responses to female sexuality from centuries ago to today. It will describe sexual addiction and treatments currently found in literature via Google Scholar and EBSCO databases, and discuss how females differ in their experiences with sexual addictions compared to men. This paper will focus on treatments at large for sexual addiction, but will narrow in on the female client. As a student of and believer in Adlerian theory, this author will also include critiques along the way that will apply Adlerian concepts to the issues being discussed.
Acknowledgements

I would like to start by thanking my family for being my constant supporters. Through years of “figuring it out” and delaying the time line, they have continued to be a source of encouragement and steadfast cheerleading. I couldn’t have gotten to this point without them!

Much thanks is also to be given to those who have invested in me as an aspiring clinician, both Adlerians and non-Adlerians alike. My theory and understandings have been shaped by creative minds, which I have been blessed to come in contact with. And to those who I have not connected with in person, but whose work has been shaping me, those who are fronting the cause for females with sexual addictions, and gathering their knowledge in joint efforts, many thanks. In particular, Marnie Ferree and the people at the Society for the Advancement of Sexual Health deserve much of this gratitude. Their recent publication, Making Advances: A Comprehensive Guide for Treating Female Sex and Love Addicts (2012), is the book I hoped to write one day. It has been shaping my understanding of this topic since I received my copy in June, and I look forward to reading and rereading it again and again.
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“In an age which highly values the variety and quality of sexual experience, there is a group which is overlooked: those who are sexually compulsive in ways they do not want to be.” ~Patrick Carnes

Sexual Addiction and the Female Client

Though the medical and psychological fields have been privately working with individuals with unwanted sexual behaviors for hundreds of years, the past few decades have made the term “sex addiction” familiar, and arguably common, to the public. Due to the increase in popular cultural figures coming forward with or being “discovered” to have a problem with sexual behaviors, public sex scandals of people such as former President Bill Clinton and Tiger Woods have become a part of our nation’s history. One needs only to turn on the news to discover current stories of the same. Anthony Weiner and Eliot Spitzer of New York, and Bob Filner of San Diego, all current politicians running for various public offices, have been recognized for their own sex scandals. These scandals have been blamed on addiction. Many of the above mentioned men have claimed that they, in fact, suffer from sex addiction and have sought treatment for the diagnostic claim. Of interesting note, all of these public figures are men. Women are recognized publically as either the object of the addiction or the victim of betrayal. But what if women also live with unwanted sexual behavior? In fact, Marnie Ferree (2010), citing research by Patrick Carnes, states that of the estimated 45% of the adult United States population who are sexually addicted, “probably 40 to 50 percent are females,” (p.71). These stats reflect those of alcoholism – another addiction historically believed to be a male problem.

What if the pain found in these men from years of secrecy is the same pain welling up in the hearts of sexually addicted women? What if the lives and reputations of these women are
just as fragile? Does the female with sexual addiction take the same form as the male with sexual addiction? Is the same treatment beneficial for both females and males? This paper hopes to answer some of these questions. It is believed that the treatments described will be found beneficial for men and possibly beneficial for women. This author does not believe this to be ethical practice. Finding treatments specifically designed for the unique differences in women with sexual addiction may be difficult. At the very least, this writer hopes to show a need for growing awareness of this problem among women, and the need for the development of treatment modalities for working with females with sexual addiction.

Focusing specifically on the female client with a sexual addiction, this paper will begin with a description of sexual addiction. It will then discuss the history of female sexuality. A review of current literature about treatment methods for sexual addiction will be given, followed by a response to the available treatments described in terms of their suitability for the female client. A broader description of sexual addiction among females will then be given. As a student of and believer in Adlerian theory, this author will also include critiques along the way that will apply Adlerian concepts to the issues being discussed.

**Sexual Addiction**

**Definition & Description**

Known for decades by an ever changing variety of names, the addiction to sexual behaviors and practices has been identified as “sexual compulsivity,” “sexual dependency,” and “hypersexuality,” to name a few (Hall, 2011). For the sake of consistency within this paper, the terms “sexual addiction” or “sex addiction” will be used throughout. Sexual addiction can be defined as “a pathological relationship to a mood-altering experience,” (Carnes, 1983, p. 135). The mood-altering experience, in the case of a female with sexual addiction, may be any one or a
combination of the following: relationship or love, romance, fantasy, pornography or cybersex, masturbation, exhibitionism, selling or trading sex, or partnering with another addict (Ferree, 2010). Sexual addiction may even include seasons of sexual anorexia (Ferree, 2010; Carnes, 1997).

McDanile and Valenti-Anderson (2012) add that sex addiction for the female client can be best understood as, “a profound inability to bond with others,” (p. 27). Though the behavior is an attempt to gain intimacy, it is a faulty one. Females with a sexual addiction are actually addicted to the pursuit and high of “falling in love” or orgasm. These take the place of actual connection with a partner. This often causes psychological isolation. Different from loneliness, psychological isolation is, “the sense that one will never connect with another, and the reason is intrinsic to the self,” (p. 28). This brings both pain and shame as the individual finds herself in circumstances that can feel both unchangeable and unending. Sexual behaviors are often what make these unmet desires bearable (Laaser & Laaser, 2008; Carnes, 1983).

This writer sees Alfred Adler’s description of the masculine protest as the closest thing he came to in terms of discussing sexual acting out. Protesting against the feminine role, he described masculine protest as girls engaging in more typically masculine behaviors, acting out sexually in rebellion, or entering into homosexual or prostitution lifestyles believing they deserved nothing higher (Ansbacher & Ansbacher, 1956). He did not seem to address sexual addiction explicitly.

He did, however, address the inability to connect with others. Adler saw clearly in children a need for affection (Ansbacher & Ansbacher, 1956). This need for affection is what leads humans into loving relationships throughout life - love of relatives, friendship, social feelings (social interest), and love. If a child’s need for affection is not satisfied, social interest is
not developed. One could argue then that the female with sexual addiction, who acknowledges an inability to bond with others, may have developed this inability due to unsatisfied goals of affection as a child. This client would then be walking through life with underdeveloped social interest as well. Adler says the task of love is a task for two. When goals of affection are unmet, the child is left with only his or her self as the goal of the desire, love becomes a task for one, and a mistaken belief is born. Along with this mistaken belief come feelings of inferiority due to the striving towards an unmet goal. In order to guard one’s self, the desire and effort to conceal this inferiority grows. All of these elements - mistaken beliefs, underdeveloped social interest, feelings of inferiority – give way to styles of living; to a Life Style.

**Etiology & the Addiction Cycle**

Many working in the field of sexual addictions look to the addict’s belief system, or Life Style, as the root of the client’s progressive addictive behaviors (McDanile & Valenti-Anderson, 2012; Ferree, 2010; Laaser, 2004; Carnes, 1983). The Life Style is influenced by our biology, and our context (family, community, media, etc.) – nature and nurture. All of these components come together to give each individual a lens through which to view one’s self, others, and the world. Carnes (1983) describes the addict’s belief system as:

…the sum of the assumptions, judgments, and myths that one holds to be true. It contains potent family messages about a person’s value or worth, relationships, needs, and sexuality. Within it is a repertoire of what “options” – answers, solutions, methods, possibilities, ways of behaving – are open to each of us. In short, it is a model of the world. [It] is the filter through which we conduct the main task of our lives: making choices. (p. 5)
Dreikurs (1989) explains that the Life Style, Carnes’ filter, is built with a collection of mistaken beliefs. These beliefs force us to misinterpret our circumstances and difficulties. Thus, the choices each individual makes, when faced with situational discomfort, are his or her efforts to gain their universal goal (security, significance and belonging) and bring ease to the discomfort.

The Addiction System follows this same path. If you refer to Figure 1 in the Appendix, you will see that the belief system, built from impaired thinking, leads to the revolution through the Addiction Cycle. Traveling around the Addiction Cycle, an individual’s inferiority is illuminated and his or her life is viewed as unmanageable. The individual’s impaired thinking is reinforced and the belief system kept in tact.

Embedded within the Addiction System is the addiction cycle. This cycle includes four phases (Ferree, 2010; Carnes, 1983):

1. Preoccupation – the trance or mood wherein the addict’s mind is completely engrossed with thoughts of sex. It is the gateway into the process of changing her mood; either from an unwanted state to a desired state, or to the re-creation of a previously enjoyable state. Brain chemicals begin to fire during this stage.

2. Ritualization – the addict’s unique routines that lead up to the sexual behavior. The ritual intensifies the preoccupation, adding arousal and excitement. This phase may last hours or even weeks depending on how long the “set-up” time requires.

3. Acting Out – the actual sexual act, which is the end goal of preoccupation and ritualization. Sexual addicts are unable to control or stop this behavior. This is the part of the cycle that is often viewed as “the problem” by the addict, the behavior that must stop, without looking to other areas for understanding.
4. Despair – the feeling of utter hopelessness about her behavior and her powerlessness.

This leads to the belief that her life is unmanageable and uses the sexual act as evidence that her mistaken beliefs are true (see Figure 1 for the complete Addiction System).

**Diagnostic Criteria**

Because sexual activity is a normal part of the human experience, and regret or shame is unfortunately common, many people wonder how to determine if the sexual behavior is an addiction, or just a series of poor choices. Though there is no standard set of diagnostic criteria for sexual addiction, many working in the field utilize a number of assessments and screening tests available on-line. In her book, *No Stones: Women Redeemed from Sexual Addiction*, Marnie C. Ferree (2010) proposes 15 questions for women to self-test for sexual addiction:

1. Have you ever thought you needed help for your sexual behavior or thinking?
2. Have you tried to stop or limit what you felt was wrong in your sexual or relationship behavior?
3. Do you use sex to escape, relieve anxiety or as a coping mechanism?
4. Do you feel guilt, remorse or depression afterward?
5. Has your pursuit of sex or a particular relationship become more compulsive?
6. Does it interfere with relations with our spouse?
7. Do you have to resort to fantasies or memories during sex in order to be aroused or satisfied?
8. Do you keep going from one relationship or lover to another?
9. Do you feel the right person would help you stop lusting, masturbating or being so promiscuous?
10. Do you have a destructive need – a desperate sexual or emotional need for someone?
11. Does the pursuit of sex or a relationship make you careless for yourself or the welfare of your family or others?

12. Has your effectiveness or concentration decreased as sex or a relationship has become more compulsive?

13. Have you experienced negative consequences as a result of your sexual or relational behavior?

14. Are you depressed?

15. Were you sexually abused as a child or adolescent?

Feree suggests that if you answer yes to even a few of questions 1-13, you are likely addicted to sexual behavior. As numbers 14 and 15 suggest, there are other psychological or circumstantial presentations that may accompany a sexual disorder. Along with depression, marital or relational issues, substance abuse, eating disorders, bipolar disorder, and personality disorders are common among those with sexual addiction (Ferree, 2010).

So, now what? A problem has been recognized and help is being sought. How does a female with sexual addiction begin the journey to healing? How do clinicians help heal the root of the problem and not just work on behavior modification? Let’s begin by looking at how female sexuality has been dealt with throughout history and work up to today.

**Female Sexuality: A History**

**The Monstrous Feminine**

The seductive and powerful siren, capable of breaking down the strongest and bravest of men, has been a common female image since the Greek Ulysses’ journey around the Aegean Sea. Throughout history, and across cultures, the woman’s body has inspired both fascination and fear. Literature and lore has described this body as “the monstrous feminine made flesh,”
provoking the idea that it is dangerous, yet also as a body that is mysterious and worthy of adoration and desire (Ussher, 2006). Woman has been depicted as powerful, impure and corrupt, and a source of moral and physical contamination; as well as sacred, nourishing, and nurturing. The woman, it seems, has always been considered a sort of Dr. Jekyll and Mrs. Hyde type of character; having one side of her good with upstanding morals, and the other side evil, filled with ideas of immorality and licentiousness.

Female reproductive functions - menstruation, pregnancy, menopause, and post-menopause – have historically caused women to also be seen as weak, erratic and unreliable (Ussher, 2006). These elements of a woman’s bodily functions were to be kept under medical watch, and at the very least kept a secret. The accompanying emotional and psychological symptoms such as Premenstrual Syndrome, Postnatal Depression and Climacteric Syndrome, offered evidence of the monster within – a pathology within a woman which is out of her control, but which could be controlled by medical experts.

Similarly, women’s sexual desire was kept under the watchful eye of the medical field as well. Though today, it is primarily men who are known to suffer from sexual addiction, it was not always the case. In the nineteenth century, nymphomania was a common diagnosis among women. Wanting or having too much sex, too much desire, or too much masturbation was unacceptable for women in those days (Groneman, 1994). Satyriasis, a similar diagnosis given to men, was considered a much milder form of the problem and was diagnosed much less frequently.

Seen as a symptom, and cause, and a disease, nymphomania was a diagnosis exclusively given to women. It was seen as a parallel to erotomania, hysteria, hystero-epilepsy, and ovariomania. Like sexual addiction, nymphomania also had several identifying names: puerperal
nymphomania (relating to or occurring during childbirth), malarial nymphomania, mild or true
nymphomania, homosexual nymphomania, platonic nymphomania, and nymphomania brought
on by pulmonary consumption and by opium. Symptoms were listed as “committing adultery,
flirting, being divorced, or feeling more passionate than their husbands,” (p. 341).

Offering examples of the polarity in thinking prevalent in the medical field at this time,
Groneman (1994) quotes Howe (1883), stating “one doctor claimed that women with blond hair
between the ages of sixteen and twenty-five were the most likely candidate,” while others saw
nymphomania as a disease of widows, virgins, or pubescent adolescents (p. 340). Nymphomania
was, simply stated, female sexuality that was considered totally out of control. Literally and
figuratively, the behavior was out of her control (the woman’s), and out of the control of her
husband, mother, and doctor. Treatment often included surgery to remove parts of the female
sexual organs. Ovaries (one or both), the clitoris, even labia were removed or modified as the
believed source of the problem (Ussher, 2006; Groneman, 1994). These practices were both
praised and criticized in the medical community. Again, a unified voice in this area was not
found. In the late 19th century, women were seen as dangerous to the family, moral order, and
civilization (Groneman, 1994). Eventually, an ideology was established that the nineteenth
century woman was (or should be), by nature, less sexually desirous than men and that her
identity was dominated by the roles of wife and mother.

**Capitalism’s Role in Sexuality**

As the twentieth-century rolled around, capitalism began contributing to role division
between men and women (Falla, 2001; Groneman, 1994). A ‘discovery’ was made that women
were passive in nature. This discovery also indicated that they had smaller, weaker brains, and
that their monthly ‘illness’ and specific reproductive organs made women ill-equipped for work
and other public participation such as college or voting (Groneman, 1994). In essence, a woman’s body and bodily functions made her and her brain weak. Women who did begin to step out of the home, career women, feminists, and educated women, who did not marry, were seen as ‘masculinized,’ (Groneman, 1994). These women also began to demand their own sexual gratification, which was seen as primarily a male trait, and thus a problem in need of a solution (Dreikurs, 1962).

These same “discoveries” that encouraged the gender role division, also shifted the focus of women’s sexual “problems” from physiological causes to psychological causes (Falla, 2001). Though biological models of nymphomania were still utilized, psychological explanations took precedence. Blame no longer ended on women’s bodies, but was now expanded to a woman’s inadequate sense of self, repressed homosexuality, or incomplete psychosexual development (Falla, 2001; Groneman, 1994). In 1945, Dreikurs would have described these women as having psychopathic personalities, believing they did not have the ability to see the rightness or wrongness of their behavior, feeling justified in their actions, and not desiring help (Dreikurs, 1945). He described two different types: (1) Indulgent Personalities: those who were general addicts or perverts, and (2) Defiant Personalities: those who were active sex perverts and prostitutes. These personality options must have kept women believing in their inferiority. Not only was their mental capability put into question, their moral development was believed to be kept at a juvenile level, and they were believed to have complete resistance to help.

Seemingly separate from role division, capitalism also shifted society from a production-oriented way of life to a more consumer-oriented way of life (Falla, 2001). Falla (2001) believes this change in societal thinking shifted opinions about sexuality as well. Carnes (1983) gives an example of this theory at play in our society: “We live in an exploitative society which ‘injures
the two sexes differently.’ …Men [are characterized] as ‘expendable warriors’…and women, ‘the inferior child-bearers.’ …Men become economic symbols. Women become sex symbols. The quintessential expression of the transaction is prostitution, i.e., money for sex,” (p. 116).

Ussher (2006) believes that the implications of this legacy of broken female sexuality have impacted the way in which we, as women, inhabit our bodies. In contemporary Western culture, idealized femininity consists of the woman as an emotional nurturer of others, in particular men and children (Ussher, 2006). The ‘good’ woman is seen as responsible, able to cope, calm, and controlled, the ‘bad’ woman as unruly, angry, and irresponsible. In addition, women are seen as sex symbols. When women are expected to be simultaneously the emotional nurturer and a sex symbol, the stories of old, along with their legacies, of the pluralistic Dr. Jekyll and Mrs. Hyde, continue.

**Current Ideas of Female Sexuality**

Today, many theories exist describing how and why humans behave the way they do. One example is cognitive social learning. This theory suggests that humans learn behaviors through observation and choice (Petersen & Hyde, 2011). Cognitive social learning theory goes on to suggest that differences in gender behavior develop due to observations of same-gender models in a child’s life. The chosen behaviors are then either rewarded or punished, and children learn to live within cultural gender norms. Because many behaviors may be found acceptable for boys and men, while not for girls and women, a double standard exists. The double standard plays a role in determining which sexual behaviors men and women are likely to imitate. For example, in 1999, Milhausen and Herold reported that “the double standard holds that casual sex and multiple sex partners are acceptable for men, but not for women (as cited in Petersen and
Hyde, 2011, p. 150).” This is not a new circumstance, however the identification of the double standard has only been strongly fought against in recent decades.

In their 2011 book, *Girls Uncovered: New Research on What America’s Sexual Culture Does to Young Women*, doctors McIlhaney, and McKissic Bush (board-certified obstetrician/gynecologists and researchers) echo the gender differences discussed above concerning attitudes about sexual behavior, adding to imitated behavior, the differences in anatomy and brain development. Men, on average, desire more sexual partners, both in the short term and throughout their lives, than women. Men begin participating in sexual behavior because they “feel ready,” while women report doing so out of affection for their partners (Michael, Gagnon, Laumann, & Kolata, 1994 as cited in McIlhaney & McKissic Bush, 2011). Women are more likely to desire fulfilling their partner’s needs or wants for sexual activity than for desiring it for their own fulfillment. In fact, research has shown that women are, “four times as likely as young men to participate repeatedly in disliked sexual activities,” (Kaestle, 2009, as cited in McIlhaney & McKissic Bush, 2011). This behavior doesn’t come without consequence, however. Teen girls tend to feel more regret for not having waited longer before beginning sexual behavior, and college women also tend to feel regret, self-blame, and shame after a hookup (Grello, Welsh, & Harper, 2006; Paul & Hayes, 2002 as cited in McIlhaney & McKissic Bush, 2011).

So why do girls and women act this way if there are such emotional consequences? The pressure to be all things to all people (Dr. Jekyll and Mrs. Hyde) seems to be a pervasive feminine pressure in western society. McIlhaney and McKissic Bush (2011) state the following: Young women often feel they have to be smart, fun, pretty, sexy, athletic, and accomplished – outperforming their male counterparts – and being sensitive to the needs
of others as well. In addition, they should be able to will themselves into being “just like
guys,” without emotions that would hinder their sexual expression and emotional
freedom. And, the culture says, they should desire and expect social and sexual
satisfaction without any negative consequences. (p. 79)

Petersen and Hyde (2011) describe cultural media (music industry, TV/film industry, social
media, print media, etc.) as offering a growing model for sexual behavior. As sexual behavior is
portrayed in an increasingly liberal manner, “providing more sexually permissive models for
both men and women to imitate (Kunkel et al, 2003, as cited by Petersen & Hyde, 2011, p.
151),” sexual behaviors in actual society are likely to be changing as well. A quick scan of
popular women’s magazine headlines confirms this.

One of the most popular women’s magazines, *Cosmopolitan*, reported the following
headlines on their July 2013 cover: “Hot Summer Sex Tricks,” “Weird Stuff Guys Think About
During Sex (even we were shocked!),” and “Sexy Outfits (you can actually afford), Prettiest Skin
& Hair (5 minutes max), and Your Best Bikini Bod (4 kick-ass moves).” With the help of this
one issue, a woman can improve her sexual performance, her understanding of the mind of a
man, and her physical self from head to toe. Not to leave the younger female population behind,
*Seventeen*, a popular teen magazine echoes with their own June/July 2013 headlines: “Look Cute
For Almost No $$$!” “The 5 Worst Things to Say To A Guy!” and “Pretty Hair All Summer.”
Magazines, however, are not the only products to capitalize on women’s sexuality. Companies
such as GoDaddy.com, Fiat, Hardee’s, and American Apparel use women in sexually explicit
ways to sell everything from cars to cheeseburgers.

Carnes (1983) stated that the sexual culture of the 1980’s created prime ingredients to the
addictive system. Now, in 2013, thirty years later, this writer would argue that a change has not
come. The information available on sexual indulgence, and the accompanying expectation to know and apply it, not to mention the constant visual availability of sexual images, continues to impose on and impact the lives of women, men, girls and boys. Today, sexual addiction ingredients have increased in number, and become more readily and easily available.

**Treatment Methodologies**

Though the above information would suggest that the problem lies in the cultural system, this paper’s focus is on change within individuals, not cultural change. Changing mindsets that began centuries ago seems overwhelming, and an impossible task. Helping to heal an individual, and hoping for an exponential effect is what this paper is about, and this writer isn’t the first to think so.

As early as 1975, many groups across the country independently began supporting sexually addicted individuals (Carnes, 1983). These groups were based on the Twelve Steps of Alcoholics Anonymous. In 1976, Patrick Carnes wrote an extended unpublished paper titled, “The Sex Offender: His Addiction, His Family, His Beliefs.” In it, he wrote of his experience conducting outpatient groups with sex offenders. Workshops, training events and programs were developed in response to this paper, and in 1983, Carnes published his first book on the subject of sexual addiction, *Out of the Shadows: Understanding Sexual Addiction*. This book helped others see the need for treatment modalities in this field.

On a broader scope than just treatment modalities, clinician competencies have also been the focus of some writings in the field of sexual addiction. In 2009, W. Bryce Hagedon shared the findings of a national study aimed at creating a list of competencies for sexual addiction counseling, within which treatment modalities fall. This followed his work in which he discussed the need for increased counselor awareness in treating clients with sexual addiction.
These competencies include the following six factors: (1) Family Counseling Interventions, (2) Pre-treatment Interventions, (3) Sexual Addiction Assessment Interventions, (4) Sexual Addiction Specialty Counseling, (5) Treatment Planning, and (6) Professional Practice.

Hagedorn went on to list these interventions, which you can find in Table 1. Discussing all six factors is beyond the scope of this review. For the purpose of this paper, this review will focus on treatment models, and elements that fall primarily within factors one and six.

The broad variety of models proposed appears mainly to be due to the difficulties in defining the disorder, the possibilities of co-morbid psychopathologies, and the wide variety of etiological determinants (Hagedorn, 2009). As specific models are later discussed, you will see that each focuses on a different combination of determinants. Since the disorder's official “unveiling” in 1983 by Patrick Carnes, there has been a lack of professional agreement on this disorder's classification (Hook & Hines, 2008). Not only has this disorder been referred to by many different names (out of control sexual behavior, sexual compulsivity, sexual addiction, hyper-sexuality, sexual impulsivity, etc.), it has also been absent from the most recent editions of the DSM, including the latest DSM-V (Hardy, Ruchty, Hull, & Hyde, 2010; Hagedorn, 2009; Salisbury, 2008; Klontz, Garos, & Klontz, 2005). This means, that to date, no formal diagnosis has been assigned.

As with other substance and process addictions, clinicians working in the field of sexual addiction often recognize the need to assess for multiple addictions or co-morbid pathologies (Carnes, 2001). These assessments are then followed by questions such as: “Are the addictions alternating?” “Are they parallel?” “Do they interact in an escalating fashion?” “Which symptoms should be addressed first?” (Schneider, Sealy, Montgomery & Irons, 2005). Common comorbidity has been found to include neurotic disorders (such as anxiety), emotion regulation
problems, and adult attention difficulties (Salisbury, 2008; Briken, Habermann, Berner, & Hill, 2007). Eating disorders, borderline personality disorder, and avoidant personality disorder have been found in women, while men have been found to also have disorders due to psychoactive substance use and additional sexual dysfunctions. Reports of childhood sexual, emotional, and physical abuse are also common among those with sexual addictions (Salisbury, 2008).

Though the variables mentioned are immense, and may overwhelm the reader or clinician, Adler (as discussed in Ansbacher & Ansbacher 1956) would not see it as such a daunting task. He would see the client in terms of neurosis. He would address the client’s level of social interest. He would assess the client’s level of activity in his or her own life. He would confront safeguarding behavior and encourage the client’s creativity. Each client would require a different therapeutic approach, developed in relationship and rooted in the client’s Life Style. It seems that in Western psychology, however, this sort of method is not often celebrated, and more likely challenged. We seem to give greater credit to evidenced based approaches containing empirical research with specific methods and steps to be followed as a prescription for the cure.

In 2005, Klontz, Garos, and Klontz stated that to date, there were no evidence based therapeutic approaches for the treatment of sexual addiction; this sentiment was echoed in 2007 by Briken, et al. Six years later, in 2013, though much has been written on the treatment of sexual addiction, outcome data on the effectiveness of these methods is still fairly absent. Based on this writer’s current search using EBSCO database and Google Scholar, this review of literature will highlight some specific models implemented by some of the leading clinicians in this field, followed by a discussion of how these methods may or may not work with female clients. Adlerian critique will be given along the way.
Patrick Carnes

To begin with, the work of Patrick Carnes will be briefly mentioned. Carnes, known as the founder of the field of sexual addiction, began the conversation about treating this problem with his book, *Contrary to Love: Helping the Sexual Addict* (1989). He has since written over half a dozen books on the subject, and continues to be a main contributor to the field via journal publications, contributions to textbooks, and on-going treatment development; all while maintaining a practice as the Executive Director of the Gentle Path program at Pine Grove Behavioral Center in Hattiesburg, Mississippi (www.pinegroetreatment.com).

Carnes’ work is based on a 30-task model (see Table 2), rooted in a 12-Step Model for Sexual Addicts adapted from the 12-Steps of Alcoholics Anonymous (see Table 3; Carnes, 2001). He believes that the success of his clients is directly linked to what the recovering person actually does. Carnes and his colleagues broke each recovery task into a list of performable behaviors as well as life competencies. Moving forward in treatment is directly related to the client's ability to check-off each task on the list. Material held in the pages of a workbook, offer direction and exercises to take an individual through these 30 tasks. Program goals beyond task completion include: education for the individual and his or her family on addiction, medication, and relapse prevention; attaining skills in problem solving, coping, and stress management; as well as the completion of psychological testing and the use of group and expressive therapy (www.pinegrovetreatment.com). Though this writer did not find outcome data on Carnes’ program, Carnes and others refer to the decades of personal research having gone into the program development plus decades of clinical experience as evidence of the usefulness of his program. The program’s website boasts in having helped people from all of Mississippi's 82 counties, 49 states, and several foreign countries. Though this language begs to be seen as
impressive, this writer would challenge the depth of healing being done. Are mistaken beliefs being transformed, or is behavior simply conforming to a more normative pattern?

**Mark Laaser**

Where Carnes’ model seems rooted in a medical model focused on symptom relief or behavior change, Mark Laaser seems to focus a bit more on the problems beneath the surface. Practicing in Minnesota, Mark Laaser, along with his wife Debbie, run Faithful and True Ministries, a faith-based recovery program for men with sexual addiction and their wives, in Eden Prairie. Laaser, like Carnes, has authored many books on the subject of sexual addiction, as well as been a prominent speaker and consultant on the treatment of sexual addiction locally, nationally, and globally (www.faithfulandtrue.com). Graduates of Carnes' treatment program themselves; Mark and Debbie use their personal experiences as a “recovering addict” and a “relationally betrayed” wife to inform much of their work.

Influenced strongly by Virginia Satir, Laaser offers treatment from the mindset “the problem is never *the* problem,” (Satir et al., 1991 as cited in Laaser, 2008, p. 43). With the sexually addicted client, *the* problem is often viewed as the unwanted behavior or sexual acting out. Laaser, however, would argue that the problem is actually deeper than the surface manifestations. Utilizing an adaptation of Satir's iceberg model, Laaser traces every case to a problem of unmet desires of the heart. He views sexual acting out as the 10% of the iceberg that is above the water line, while the 90% below contains aspects of our minds and the desires of our heart (see Figure 2). It is in this 90% that the *true* problems lay. This is where treatment must be focused.

Laaser's treatment program includes a combination of individual therapy, group therapy, couples therapy, couples group therapy, and weekend intensives (M. Laaser & D. Laaser,
personal communication, May 30, 2013). The treatment plan takes his clients through five components: Healing Shame, Stopping Fantasy, Stopping Rituals, Stopping Sexual Behaviors, and Healing Despair (Laaser, 2004). Though behavior modification is found within this model, it also includes personal transformation as well. These components are cyclical; success in one area will flow into success in the others (see Figure 3). Addressing individual healing for the wife of an addict, or processing treatment for couples together, are additional values of Faithful and True Ministries (www.faithfulandtrue.com). Laaser and his wife encourage couples to stay together, encourage the wife to join in the healing journey, encourage couples to take mutual responsibility for the “disease of their relationship,” and encourage both partners to confront trauma in their pasts (Laaser, 2004).

Like Carnes, Laaser believes his clients' recovery has direct correlation to the amount of effort he is willing to put in (Laaser, 2004). Each component of Laaser’s model holds three to six behaviors the client must participate in, in order to continue forward movement in treatment. Though similar in appearance to a behavior modification model, because it is joined with deeper layers of healing at an individual’s core, this writer does not believe this to be another model of symptom relief and behavior modification. This writer sees Laaser’s methods as consistent with Adler’s beliefs about a person’s degree of activity within his or her life, and an emphasis on forward movement (Ansbacher & Ansbacher, 1956).

Additional focuses in Laaser's treatment which address the core of an individual include healing from abuse and other traumas, healing relationships, addressing codependency, addressing slips and relapse, maintaining a spiritual journey, and developing a vision for his or her life. Like Carnes’ work, this writer did not locate outcome data for Laaser’s model.
Interventions Including Outcome Data

**On-line psychoeducation.** The most recent study located by this author is Hardy, Ruchty, Hull, and Hyde's 2010 study of an online psychoeducational program. In this study, Hardy, et al., collect outcome data on the Candeo online recovery program offered to help those with problematic pornography use (www.candeocan.com). This program uses a model of treatment-based theories of addiction and compulsive dysfunction, and is rooted in Cognitive-Behavioral Therapy (CBT; Hardy, et al., 2010). The program consists of ten psychoeducational modules delivered online that the user can access at his or her own pace. Homework is given and group forums, blogs, and personal “coaches” are available. The program believes that it can provide adequate social support, help participants to be more open and introspective, and reduce shame, guilt and isolation much like a client may experience in a group therapy setting or 12-step group. Goals of Candeo participants include reduction, and most often elimination, of pornography use, and at times, reduction or elimination of masturbation.

Data on the effectiveness of this program was obtained through a uniquely designed survey that matched the constructs of the Candeo program (Hardy, et al., 2010). 138 participants (97% male) who had been active in the program for at least four weeks provided self-report, retrospective data on their perceptions of the program's helpfulness compared to other forms of treatment. Personal perceptions of the participant’s own percent of recovery was also collected.

Results showed that, on average, no other forms of treatment were perceived to be *more helpful than Candeo* (Hardy et al., 2010). This was based on a 5 point likert scale with 1 being *much less helpful than Candeo* and 5 being *much more helpful than Candeo*. If the form received a 3, it was deemed *about as helpful as Candeo*. The most commonly utilized forms of additional treatment were books, individual counseling, clergy, and 12-step programs. On
average, all of these forms received a 2 on the scale, *somewhat less helpful than Candeo*.

Additionally, the participants reported that they had more fully recovered at the time of the survey than they had prior to participating in the Candeo program, both psychologically and behaviorally.

Participants reported that they, on average, had more constructive reaction to temptation, positive affect, perceptions of agency or self-control, meaning in life, connection to others, feelings of being forgiven, awareness of thoughts and tempting situations, and healthy pleasure outlets (Hardy et al., 2010). They also reported fewer obsessive sexual thoughts, less negative affect, and a lower tendency to deny responsibility for the problematic behaviors than prior to Candeo. Behaviorally, the results were difficult to determine at first. Hardy et al. manipulated the results by “Winsorizing” them (for a description of this process, see Hasings, Mosteller, Tukey, & Winsor, 1947, as cited in Hardy et al., 2010). This allowed Hardy et al. to test their hypothesis about behavior change. In terms of pornography use and masturbation, those who increased their ability to react to temptation in constructive ways, increased their feelings of being forgiven, and learned alternative, healthy pleasure outlets (all aspects of the Candeo program) were able to decrease their pornography use and frequency of masturbation.

Hardy et al. (2010) state that without studies involving randomization of participants, it is still unclear to what extent the effectiveness of Candeo actually is compared to other treatments. Additionally, because the program runs at the users’ pace, four weeks of participation can still put each user at varying places along the 12 module continuum. That being true, this study did show Candeo to be helpful for the subjects who participated, and may help others to decrease pornography use and masturbation. This study showed the usefulness of one on-line program,
and points to potential effectiveness of other on-line programs as well. Future studies are needed in order to determine so.

This writer’s observations about Candeo begin with the programs apparent belief that a twelve-module course will bring an end to an individual’s problems with sexual addiction. If the problem is just the unwanted behavior, then the program seems to be meeting it’s goals. If a therapeutic goal, however, is about whole person healing and integration, this behavior modification model seems to be off the mark. This may be a valid critique of all on-line treatment, or it may be more of a critique on CBT, which has a strong emphasis on behavior.

Additionally, this program lacks relational consistency. One of the “values” of pornography use online is the ability to be anonymous. Where anonymity (not to be confused with confidentiality) is maintained, how does social interest develop? The online program can be just as anonymous, and may be just as socially disinterested. There is no space to test reality, as in the context of an in-person setting. In the physical presence of a therapist, relational interaction encourages active participation in one’s own life, as well as the development of social interest. This is also possible with in-person group therapy.

**Group therapy.** The only additional outcome data study located by this author was from Klontz, Garos, and Klontz (2005), which reports on the treatment outcomes of 38 individuals with sexual addictions who participated in a brief residential, multimodal experiential group therapy treatment program. Therapeutic groups have long been found to be useful as an addition to individual therapy (Line & Cooper, 2002). Types of groups include long-term interpersonal therapy groups, encounter groups, psychoeducational groups, cognitive-behavioral groups, psychodynamic groups, and self-help groups, to name a few (Yalom & Leszcz, 2005). Many clinicians have specifically exampled the usefulness of group therapy for sexual addiction in
both inpatient and outpatient settings (Hook, J. N., Hook, J. P., & Hines, S., 2008; Klontz, B. T., Garos, S., & Klontz, P., 2005; Line, B. Y., & Cooper, A., 2002; Nerengerg, A., 2000). Yalom's 11 therapeutic factors of change are often utilized to develop these group experiences (Hook et al., 2008; Nerengerg, 2000; Yalom & Leszcz, 2002). In an article written by Nerengerg (2000) on the helpfulness of Yalom's therapeutic factors in a sexual addiction group, clients rated Group Cohesiveness, Catharsis, Universality, and Interpersonal Learning as most helpful during their group therapy experience. Confession of embarrassing things about self and still finding acceptance offers a sense of security and belonging, and brings truth to mistaken beliefs about an absence of worth. These are elements of intimacy that addicts both fear and crave as part of their universal goal (Nerengerg, 2000; Carlson et al., 2006). For a description of how additional therapeutic factors impact a group for sexual addiction, see Nerengerg, 2000.

Group therapy allows the sexually addicted client the opportunity to enter into relationships which will help him or her to manage addictive behaviors, explore the dynamics of their addictive process, and develop intimacy in meaningful nonsexual ways (Hook et al., 2008). Adler believed in this concept through his understanding of social interest (Dreikurs, 1989). When a person is able to find something in common with another human, his or her capacity for co-operation can improve. The group can master their problems together, formulating common sense vs. private logic. The stronger an individual’s social interest becomes, the easier it will be to achieve success in his or her life tasks. Peer accountability and challenge, both elements of social interest, become meaningful aspects of the group dynamic for the sexually addicted client (Hook et al., 2008). The addition of peer validation, or in Adlerian terms, encouragement, is especially important (Hook et al., 2008; Dreikurs, 1989). This rests, not only in the assumption that sexual addiction may be a disorder of intimacy rooted in attachment problems, but also
because of the societal and cultural perceptions these clients face (Hook et al., 2008; Line & Cooper, 2002). The shame an individual with a sexual addiction carries, impacts his or her ability to maintain a sense of self-worth (Hook et al., 2008). Validation increases an individual’s capacity for self-empathy and self-understanding (Line & Cooper, 2002).

The group setting also becomes a place to test reality and express affective sexuality through the creation of new group values (Hook et al., 2008; Dreikurs, 1945). “A therapy group is a more realistic social unit because each member brings his interpersonal problems to the situation. In learning to cope with the interactive problems of various group members, the [sexually addicted individual] learns how to manage real life relationships,” (Schwartz, 1995 as cited in Line & Cooper, 2002, p.17). Goals for group therapy may include: (1) decrease the shame experienced by participants; (2) develop an understanding about their motivations and behaviors (i.e., triggers, feelings, cognitive distortions, “slippery situations,” purpose of the behavior, etc.); (3) increase their awareness of their own interpersonal style; and (4) develop more effective coping mechanisms for dealing with difficult emotions, situations, and problems (Line & Cooper, 2002). Duration and participation expectation of group therapy can range from open-ended groups with a certain number of months expected as minimum commitment, to closed groups with a set number of sessions (Hook et al., 2008; Line & Cooper, 2002).

In 2005, after showing the need for evidence based practices in the treatment of sexual addiction, Klontz et al. conducted research on the effectiveness of a brief residential, multimodal experiential group therapy treatment program. Through the integration of experiential therapy and cognitive-behavioral techniques, the study aimed to reduce shame, resolve the client's past trauma or unfinished business, and address the client's addictive thought and behavior patterns. The core theory and techniques utilized were based in psychodrama and role-playing. Klontz, et
al., also utilized art and music therapy techniques as well as Gestalt techniques for group warm up times. This particular program was offered in a retreat-type setting with 32 hours of intensive group therapy time and 12 hours of psychoeducational seminars. Additionally, homework assignments were given during evening hours, which were adapted from Patrick Carnes' 2001 workbook, *Facing the Shadow: Starting Sexual and Relational Recovery*.

Klontz et al. (2005), studied five separate eight-day programs within a 12-month period utilizing the Brief Symptom Inventory (BST) and the Garos Sexual Behavior Inventory (GSBI), both standardized measures of treatment outcome, as well as anxiety, depression and obsessive-compulsive scales. A total of 53 individuals participated, but data was only utilized for the study from 38. Follow-up data was also collected at an average of 6-months following treatment. Following the program, 89% of the participants regularly participated in 12-step Recovery programs and 87% participated in outpatient counseling.

Though this study lacked experimental controls and relied solely on subject self-report methods, the study added promising empirical outcome data to the field (Klontz et al., 2005). Results indicated that significant reductions in overall psychological distress were achieved in male participants from pretreatment to posttreatment, including at the six-month follow-up. In the female participants, reductions were also found at posttreatment. However, the continued reduction was not statistically significant at six-month follow-up. This writer wonders if this was due to the lack of sustained relationship following a “weekend away” format vs. a group setting of common community members with the potential for sustained relationships. Similar differences were found for specific obsessive-compulsive symptoms, such as intrusive thoughts about sex (sometimes considered an underlying element of obsessive-compulsive disorder; Klontz et al., 2005). Men showed significant reduction in symptoms, while women showed only
marginally significant reduction. Both men and women showed significant reductions in depression and anxiety symptoms. Preoccupation with sexual stimuli and difficulty controlling impulses also showed change in positive directions for men and women from pretreatment to posttreatment, and at the six-month follow-up.

Elements of this program that did not go as predicted included a decrease in feelings of comfortability with sexual arousal, as well as no improvement in feelings of conflict, shame, or remorse (Klontz et al., 2005). This, however, does not imply that the program failed its participants. These results may simply indicate the importance of treatment beyond an eight-day program. This program may have proved to be useful as a seed-planting element of an individual’s treatment journey, evidenced by an improvement in feelings of conflict, shame, and remorse at the six-month follow up. Another potential reason for these unintended outcomes, may be due to an over emphasis, again, on behavior modification rooted in CBT methods. The areas that lacked improvement are those dealing with an individual’s concept of self, his or her sense of security, belonging, and significance.

**Interventions Excluding Outcome Data**

As mentioned above, many have added to the library of writings about treating sexual addiction without providing outcome data. Personal models of treatment, as well as specific interventions within treatment have been included. Though no formal research has been conducted in order to provide evidence based outcome data, the following authors have documented individual case studies.

**Personal models.**

**R. M. Salisbury.** When looking at the complexities of addressing treatment needs for clients with sexual addictions, R. M. Salisbury (2008) begins by identifying all out of control
sexual behaviors the client is involved in, and how these behaviors became problematic for the client in the first place. Salisbury's belief is that the core etiological explanation for sexual addiction is an underdeveloped ability for intimacy enhanced by distorted attachment behavior which is often caused by childhood trauma (sexual abuse or neglect). This would line up with Adler’s understanding of the problems in people’s lives. Dreikurs (1945), states that, “all conflicts of any human being are social conflicts, resulting from a disturbance or straining in the social relationship of the individual, impairing his integration into the community and obstructing his participation in the social functions,” (p. 122). When affection needs go unmet, an individual will turn to his or her self for the fulfillment of those needs, thus inhibiting intimacy and attachment with others. From this core distortion, Salisbury (2008) determines the trajectory of treatment based on four broader etiological subgroups:

1. Impaired affect regulation – when a person uses sexual behavior to self-soothe or as a distraction.

2. Impaired behavioural inhibition – when a person has deficits in his or her ability or motivation to inhibit sexual responding.

3. Motivational reward system – when the pleasure that accompanies sexual behavior and its outcome (i.e. orgasm) becomes reinforcement for future sexual behavior. In essence, the person becomes addicted to the pleasure and the outcome of sexual behavior.

4. Self-regulatory failure – when a person is unable to maintain his or her personal set of standards based on morals, values, beliefs, or goals; for example, behavioral standards which are guided by religious beliefs and practices.

Salisbury (2008) goes on to propose stages of therapy:
1. Intimacy with Therapist – this stage begins with the formation of a trusting therapeutic relationship. This stage also includes grief work, trauma resolution, and a focus on undoing defenses in the here-and-now connection of the therapeutic relationship. The therapist also provides well-boundaried attachment conditions and psycho-education. From an Adlerian perspective, this is where the identification of mistaken beliefs begins. This is also where social interest can begin to be redeveloped.

2. Intimacy with Self – the client learns to address his or her sexual and emotional needs appropriately. The client practices identifying and holding emotions as well as being compassionate to all “sides” of self. Aspects of the client's life, including boundaries, power, intimacy, self-respect, and self-care, are also addressed. This is where mistaken beliefs begin to be unpacked and reframed, and role-playing can be integrated to test reality, or prescribing the symptom can be utilized to increase insight.

3. Intimacy with Others – in this stage, the client is encouraged to integrate skills learned in the previous 2 stages into relationships outside the therapeutic relationship. The client addresses ways in which his or her behaviors have hurt friends, family, and others in his or her life. This is also when a client would be encouraged to resume loving sex with a partner. This is where social interest is put into practice in a deeper way.

Through this process, Salisbury (2008) proposes that a client's desires for problematic sexual behaviors would be, “reframed into emotional needs to which the client [has learned] to respond effectively. It is proposed that this work [develops] the capacity for intimacy by [intertwining] the cognitive behavioural, individual, couple and group work described by others in the field (e.g. Kafka, 2000),” (p. 138).
Schneider, Sealy, Montgomery, & Irons. Schneider, Sealy, Montgomery, and Irons (2005), look at addiction through a poly-addictive lens. This lens takes into consideration the potential of co-morbid addictions. Specifically, this team assesses the co-morbidity, or poly-addiction, of drug and sex addiction. Schneider et al., propose a focus during treatment on desire and craving, ritual and reinforcement, avoidance of past trauma and anxiety, and employing cognitive distortions and narcissistic defenses. In other words, they address all areas of safeguarding the client may be utilizing in his or her efforts to conceal inferiorities.

They suggest desire and craving underlies all addictions as part of the addictive process (Schneider, et al., 2005). Desire and cravings also underlie the strong drive life (Ansbacher & Ansbacher, 1956). Not all of these desires or cravings are bad, but learning to discern useful methods of fulfillment is a goal of treatment. Their definitions point to the longings that humans experience for what he or she does not have as well as the desire to escape some sort of mental or emotional pain. This seems to echo Laaser’s (2008) idea of unmet desires of the heart, as well as line up with Salisbury's (2010) first subgroup, Impaired Affect Regulation, and Adler’s universal goals of safety, belonging, and significance.

Because of these longings and desires, Schneider et al. (2005), suggest an emphasis in treatment on the understanding of the addiction cycle (or addictive process) with a specific focus on ritualistic behavior. Schneider at al., describe ritualization as the behavior that enables a client to protect their addictive process. When reality threatens one's desires and cravings, ritualization keeps reality at bay, keeps inferiorities from surfacing. Boundaries, rational thinking, and emotional regulation all take a hit when a client is cycling through the addictive process. This cycle continues to spiral downward like a tornado until a person hits bottom and pursues treatment.
In addition to understanding a client's underlying cravings and desires, and the addictive process, Schneider et al. (2005) emphasize understanding a client's “characteristic spin” or “bias” on the way in which they view the world; in Adlerian terms, it is important to understand the client's Life Style (Carlson, Watts, & Maniaci, 2006). Understanding wounds and other life events from an individual's past, may help uncover the lens through which the client is viewing self, others, and the world (Schneider, et al., 2005). For such an uncovering, the use of recording Early Recollections has been utilized in Adlerian therapy (Carlson, et al., 2006). These experiences may include sexual abuse, childhood trauma, neglect, or abandonment; as well as additional emotional trauma including domestic violence, urban violence, or military combat (Schneider, et al., 2005).

Schneider, et al. (2005) propose narcissism as the primary characteristic which perpetuates the addictive cycle. For the person with the addictive behavior, other people are seen only as objects, or extensions of the individual, whose primary purpose is to gratify the cravings of the addict. Desire partners with this as additional reinforcement because, “when it is gratified, it sets off a cascade of neurochemical events associated with the pleasure centers in the brain,” (p. 125). This, again, echoes a subgroup of Salisbury (2008) - Motivational Reward System. Schneider et al. (2005) offer hope to this process, however, by reminding their readers that though desire is compulsive, the intention to act can be changed.

In treating poly-addicted clients, specifically those with co-morbid sexual and drug addictions, Schneider, et al. (2005) also look at the specific kind of acting out that takes place. One area of focus in their article was the solo addict, one who acts out alone, without other people. In treating the solo addict, Schneider et al., stress an understanding of this type of client's characteristics. These include: (1) isolation, which offers freedom from connection and
vulnerability; (2) the illusion of power, which denies needs and promotes narcissistic fantasy; (3) objectification, which requires the shutting off of compassion; (4) loss of spirituality, due to its potential to threaten omnipotence; and (5) shame, the deep belief that if someone knew about the addiction the client would be ultimately rejected. These elements all echo Adler’s previously mentioned beliefs about the individual who turns to self for affection fulfillment, which delays the development of social interest – the very thing they are longing for. Additionally, for the solo addict, overcoming emotional isolation (as opposed to strictly physical isolation) is a therapeutic goal Schneider, et al. (2005) propose. They view isolation as a distortion of privacy. In Adlerian terms, the establishment of these boundaries is necessary to safeguard from exposure of inferiorities. Because of this, establishing community is mandatory. Schneider, et al. suggest one accomplishes this through connection with a higher power, to peers, 12-step programs, the therapist, partners, and the self. Again, this gives evidence to the importance of the development of social interest.

S. A. M. Valenti. Valenti (2002) proposed, through a case study of a female with sexual addiction with an etiology of past sexual trauma, a model based in Object Relations and Self Psychology. Valenti suggests that the client's mistaken beliefs are caught in transference phenomena. Transference phenomena occurs when, “a person believes his or her inevitable fate is the continuation of the traumatic legacy...or the experience of compelling, identity-defining, and pervasive conscious or unconscious life themes,” (Baldwin, 2002 as cited in Valenti, 2002, p. 249). It is the belief that there is no hope for a change in their reality.

In treating such clients, Valenti (2002) utilized several treatment components, much like Hagedorn (2009) would later suggest: individual psychotherapy one to three times weekly, pharmacotherapy, group therapy weekly for survivors of sexual trauma, 12-step groups one to
three times weekly, spiritual support (through church fellowship and literature), friends for
support and companionship, and occupational involvement (gradually increasing from part-time
to full-time). During individual therapy, Valenti reframes past trauma, develops individuation,
and builds differential development. The goal is to help connect the client to a stronger sense of
self-efficacy, self-value, and self-regulation of needs and wants. Valenti took on the challenge of
developing an approach that would heal her client's, “broken spirit (love and support), confused
mind (psychotherapy), and abused body (medication),” (Valenti, 2002, p. 258).

**Specific interventions.**

*Motivational interviewing.* Motivational interviewing has been proposed as a treatment
method that is well suited for the treatment of sexual addiction (Del Giudice & Kutinsky, 2007).
At the time of their article, Del Giudice and Kutinsky discovered no identified empirically well-
validated treatment approaches for sexual addiction via the American Psychological
Association’s Society of Clinical Psychology's Task Force on Psychological Interventions.
Because of this, they view their article as another offering into the empirical framework for
research into treating this population.

The wide variety of techniques, in motivational interviewing, was not discussed. Specific
techniques highlighted include: reflective listening, use of affirmations, reinforcing “change
talk”, and “rolling with resistance” (Del Giudice & Kutinsky, 2007). It is suggested that these
techniques, used during the front end of treatment, not only benefit the therapeutic relationship,
but also hold specific benefits for the client with sexual addiction.

Reflective listening helps the client to feel truly heard – offering a sense of security,
belonging, and significance (Del Giudice & Kutinsky, 2007). For a sexually addicted client,
feelings of alienation, rejection, or being misunderstood or stigmatized may cause initial
hesitation to trust the therapist. Being heard may build the groundwork for future collaboration during treatment, and help model social interest for the client to utilize in relationships outside the therapeutic setting. Use of affirmations during sessions builds on this. Encouraging the client through verbalization of his or her strengths may foster a sense of worthiness the client's unwanted behaviors have deteriorated, and begin creating a desire for change. Reflection of “change talk” continues to promote these intentions. The therapist assists the client in formulating a contract with his or her self designed to promote self-efficacy and personal responsibility (Miller & Rollnick, 2002, as cited in Del Giudice & Kutinsky, 2007). This could include instances of “acting as if,” where the client is asked to behave in their life as if their desired change had already taken place. “Rolling with resistance,” in motivational interviewing, sees resistance as a “consequence of the therapist's behavior” (Del Giudice & Kutinsky, 2007, p. 308). It may be a sign of safeguarding due to a resurgence of insecurity and loss of a sense of security, belonging, and significance. By factually stating resistant statements, the therapist maintains an attitude of emotional neutrality and continued support, and helps to ensure the feelings non-judgmental attitudes from the therapist towards the client. When working with a client with sexual addiction, the unconditional alliance is seen as the key to change in the context of the client-centered perspective in Motivational Interviewing.

Psychotropic medication. In a case study of a 47-year-old single white female with non-paraphilic sexual addiction (involving normative, non-deviant sexual thoughts or behaviors), Elmore (2005) describes the use of several psychotropic medications to decrease the client's symptomology. Among the medications used were Effexor, Depakote, and Risperdal. These helped to block her hypersexuality while she maintained the capacity for normal sexual relations and orgasm. Mood and energy improvement were also experienced while being treated with
venlafaxine and sodium valproate. These medications were utilized at varying times and at modified dosages over a period of several years. Elmore adds this patient's response to previous un-cited reports about the use of psychotropic medications in treating non-paraphilic sexual addiction. Elmore made no reference to additional treatments being paired with medications, nor did he comment on his opinion of the results being successful or not. This method is purely about behavior modification.

**Therapeutic stages and 12-step programs.** In Goodman's 1998 book, *Sexual Addiction: An Integrated Approach*, cited by Briken et al. (2007), a three stage psychotherapeutic model for treating sexual addiction is suggested. Behavior modulation is the focus of Stage I. This can also be understood as behavior modification, or the process of changing behavior. Modulation of addictive sexual behaviors is sought using inner motivation, psychological support and affect-regulating medication (SSRIs). In Stage II, stabilization of behavior and affect become the treatment goals. Clients are taught to distinguish between forms of sexual behavior that is high-risk and those that are low-risk. Clients are asked to refrain from high-risk engagement, and to learn to engage in sexual behaviors in a healthy manner rather than pathologically. Stage III focus on personality pathology through psychodynamic psychotherapeutic approaches.

Goodman’s approach is completely counter to the Adlerian approach. He seems to be stuck in treating Satir’s top 10% of the iceberg (see Figure2), behavior modification, with no focus on personal transformation, the other 90% of an individual’s life. There is no apparent underlying belief that the client is anything more than his or her behavior, and to make discomfort go away, one simply needs to change their behavior to that of the majority norm. Does this then imply that changing behavior is a change of self? That changing behavior causes inferiorities to disappear? This approach would also suggest that every person has the same goal.
Adler would argue that each person has an unknown goal, unique unto him or her self, rooted in his or her own creativity. Behavior modification, fitting of the majority norm, implies that social interest is about conformity. This writer believes that Adler’s idea of social interest had more to do with each individual offering something unique and creative to the greater community; that Adler said, with Aristotle, “The whole is greater than the sum of its parts.” This is something 12-step groups can add to the treatment picture.

In Sussman's 2007 review of teen sexual addiction, he suggests that the use of existing substance addiction treatment models may be beneficial in treating teen sexual addiction. Citing Hovarth (1999), and Sussman, Skara, and Ames (2006), Sussman (2007) lists the Minnesota Model (based on the 12 steps of Alcoholics Anonymous), the therapeutic community model (in which those being treated are also co-treaters), family therapy (or other group therapy), and CBT as possible models. Sussman also suggests that others have grasped this idea, particularly in relation to the 12-Step model. He lists five nationwide self-help organizations that have surfaced: Sexaholics Anonymous (www.sa.org), Sex Addicts Anonymous (www.saa-recovery.org), Sex and Love Addicts Anonymous (www.slaafws.org), Sexual Recovery Anonymous (www.sexualrecovery.org), and Sexual Compulsives Anonymous (www.scarecovery.org). These programs offer a sort of mini-community setting for each member to begin putting his or her developing social interest into practice through his or her unique, creative voice.

**Females and Research**

It has been thoroughly documented and established that psychological problems present themselves differently based on gender (Becker, Perry, & Westenbroek, 2012; Woodall, Morgan, Sloan, & Howard, 2010). This would imply that the presentation of sexual addiction would also
differ by gender, and thus the treatment should differ as well. For example, Ferree, Katehakis, McDaniel, Valenti-Anderson, and Vermeire, (2012) believe, like many others in the field, that sexual addiction is a problem of disordered regulation due to a fundamental attachment disorder. They go on, emphasizing the importance of the therapeutic relationship for the female client.

Citing Schore, 2012, Ferree et al., acknowledge the impact of attachment trauma on the right brain's affect regulation. Thus, one goal of therapy would be to reintegrate the left and right hemispheres of the brain. Ferree et al. share Schore's belief that, “the best way to integrate the right and left hemisphere…is by working with the implicit right hemisphere significantly more than the left hemisphere,” (Ferree et al., 2012, p. 96). Establishing a “right brain-to-right brain connection” and maintaining an attunement to the client’s regulating mechanisms become important for the clinician working with a sexually addicted female. Do current sexual addiction intervention methods acknowledge or provide these elements for the female client?

Patrick Carnes’ Task Model is often recognized as part of the standard of care for sex addicts (Ferree et al., 2012). These tasks, however, are largely cognitive-behavioral, or left brained. Ferree, et al., suggest that though men may see a task as an opportunity to “get to work,” “get something done,” and “move on,” a woman may view the same task as, “either a movement away from her therapist ('I just want to talk') or a distancing mechanism ('Can't you handle me?'),” (Ferree et al., 2012, p. 97). Ferree et al., believe Carnes' tasks can be beneficial for the female client, but may be more beneficial when done in connection with the therapist rather than as homework, as is often the method of task execution; thus engaging the right and left hemispheres of the client. This, however, remains a theory without outcome data.

In the above review of literature, 1/3 of the case studies included female clients; however, only two discussed outcome differences between the genders and only one of these in depth.
Sussman (2007) suggested that there were simply too few female sex addicts for confident responses to be made about etiology or treatment. Historically, the exclusion of women in research has been partially based on a view that women of childbearing age proposed too great a risk if pregnancy were to occur during treatment trial (Woodall et al., 2010; Weinberger, McKee, & Mazure, 2010). The fear was that the baby could be put in harm. Since 1985, however, the National Institutes of Health (NIH) has been promoting increased attention to the deficit of women's representation in research (Weinberger, et al., 2010). Guidelines concerning the inclusion of women as subjects as well as the evaluation of gender differences in outcomes were developed and set in place in the late 1980's. According to the United States General Accountability Office (GAO), however, the policies have not been adequately communicated or implemented. In 2001, the NIH published the following amended guidelines for the inclusion of women and minorities in research:

> It is the policy of NIH that women and members of minority groups and their subpopulations must be included in all NIH-funded clinical research, unless a clear and compelling rationale and justification establishes to the satisfaction of the relevant Institute/Centre Director that inclusion is inappropriate with respect to the health of the subjects of the purpose of the research. (Woodall et al., 2010, p. 2)

Though enrollment of women in clinical trials has gone up, reviews conducted in 2004 found as many as 87% of studies continuing to lack attention toward gender-specific outcome data (Weinberger et al., 2010). In Klontz et al.'s 2005 study, less than 1/3 of the sample were women, while Hardy et al.'s (2010) study included only a 3% female population. One article in particular discussed the outcome differences based on gender in a thorough manner.
Schneider, et al. (2005), in their discussion on poly-addiction, described the difference between how poly-addiction plays out for women. They state that one of the main differences is that for women, the addictions are typically played out in relationships (a finding also represented in Ferree et al.'s, 2012 work). Another difference lies in sexual childhood trauma. Up to 80% of female alcoholics were sexually abused as children (Schneider, et al., 2005). It is inferred that a similar percentage would be found among women with sexual addiction alone. For many women, sexual acting out becomes their way of trying to create a better outcome than their sexual trauma offered them, trying to fulfill their goals in mistaken ways. Carnes, as sited in Schneider, et al. (2005), found that women, “[tend] to be excessive in behaviors that distort power either in gaining control over others or in being a victim (e.g., fantasy sex, seductive role sex, trading sex, and pain exchange)…[using] sex for power, control, and attention,” (p. 133). This is their way to safeguard, but in their safeguarding, they often re-traumatize themselves. Because of this, many women with poly-addiction suffer from Post Traumatic Stress Disorder (PTSD), and need treatment that focuses on healing these trauma wounds and equipping them with coping skills while decreasing their addictive behaviors. Schneider, et al. (2005), suggest that treatment for women generally needs to focus on problems such as low self-esteem, guilt and shame, lack of assertiveness and decision-making skills, and personal relationships; a focus on mistaken beliefs. Working on these areas early in treatment will help prevent relapse. Additionally, overcoming codependency and developing a healthy body image, getting in touch with their own power, dealing with trauma issues and dealing with issues in the context of their relationships (additional healing of mistaken beliefs and underdeveloped social interest) will help clients to move forward in treatment.
Valenti (2002) sited a case where she worked specifically with a sexually addicted female. Valenti quotes this client:

“Lots of people minimize the danger and despair of sex addiction.... I needed guidance about how to do the healthy dating thing, like, no sex on the first date! I think maybe because I looked better outside than I was feeling inside that nobody knew where, or how, to dig deeper. And if they didn't know how to dig then I sure wasn't going to let my walls down fully. No way was I going to be vulnerable and fall apart if nobody was able to put me back together again,” (p.259).

Though this may sound like codependence, to this writer, it sounds like the voice of a child looking for her mother or father. Someone has said that counseling is the work of parenting, and this may be evidence of that statement's truth. Many clients may feel this way about therapy, but for the female sex addict, another level of therapeutic alliance seems to be required; one with deeper sensitivity to attachment history and needs, and where the client feels safe, secure, and heard; where they find belonging and know their significance (Valenti, 2002; Corley, 2012).

This gives weight to the aforementioned statements concerning the importance of the therapeutic relationship with sexually addicted females.

Considerations for Treating Female Clients with Sexual Addiction

Do these treatments, which have been developed for the man with sexual addiction, work for women? This writer believes the answer is “not quite”. Though many of the elements may be the same, the execution of them may need to be different. Differences in the expression of, comorbidity, and course of the addiction need to be considered. Intentional additions and/or exclusions may be beneficial based on these differences. One author, in her review of literature on gender and its intersection with mental health, discovered that gender differences exist even
for symptoms of the common cold (Andermann, 2010). In terms of verbal expression, men were found to more easily discuss physical distress using simple descriptions, while women discussed emotional distress, with a larger variety of words and metaphors. Men used words such as “stuck” to describe their feelings and blamed external circumstances, while women painted emotional narratives focused on shame, guilt, and personal responsibility. Because sexual addiction is described as a problem rooted in biological, psychological, and cultural wounds, differences in prevalence and course of illness, the impact of biological, psychological and social factors in the cause of illness, as well as gender differences in emotional development, and cultural expressions of emotion may help when determining treatment modalities (Judd, Armstrong, & Kulkarni, 2009).

Biological components of a woman’s reproductive lifecycle, accepted social treatment and position, and brain structure all impact her mental health. Additional considerations are “her age, her physical status, her housing situation, her role within her family, the presence of any children, and her level of financial security,” (p. 107). Women’s body image must also be considered when treating a woman. Negative body image has been linked to many physical and emotional disorders (Andermann, 2010). Influenced by the mass media, perpetuation of socio-cultural norms by friends and family, as well as natural conditions that women can not control, a negative body image can lead to anorexia, bulimia nervosa, obesity, depression, anxiety, or sexual addiction, to name a few.

**How Female Addicts are Different**

**Naming the problem.** In the beginning of this paper, the term “sexual addiction” was determined to be the name to be used throughout this paper. The reason was because it is the most common vernacular utilized in the public arena. The problem with using this name,
however, is how it misses key components to the female addict’s experience (McDanile & Valenti-Anderson, 2012). Not only can she identify the behaviors she desires to change in her life, the female with a sexual addiction can also identify the feelings that follow her behavior and the desires that led her there. Her human need for intimacy and connection, her desire for affection, is what drives her addiction. As one addict stated:

I hate that term! Don’t people understand that this has nothing to do with sex? It’s not about sex at all. It’s about that desperate need for love, for acceptance, for affection, and for affirmation. (Ferree, 2001, p. 289)

Like males with sexual addiction, most females with sexual addictions sustained either psychological neglect or emotion, physical, or sexual abuse as young girls while they were trying to understand and trust human connection (McDanile & Valenti-Anderson, 2012; Ferree, 2010). The template, which developed as a result, her Life Style, contains many mistaken beliefs concerning her ability to sustain relationships and intimacy as an adult. She likely also contains mistaken beliefs about her equality with her male counterparts. Adler believed that for intimacy to be developed, there must be a sense of equality between the two parties (Ansbacher & Ansbacher, 1956). Neither partner can feel overshadowed. If the above quoted female is only concerned with her need for love, acceptance, affection, and affirmation, she will likely cause her partner to feel mutually inferior. Both partners must desire to offer these attributes mutually to one another. There must be cooperation if intimacy is to be fostered and a space for healthy sexual expression is to be created.

We saw in the discussion of the history of female sexuality that females also sustain a wounded cultural inheritance when it comes to their sexuality. Understood as a basic human need, female sexuality “is hijacked…in a culture that teaches her to reject being sexual in order
to be ‘good’ or use sexuality as a way to gain ‘power’ which means she is ‘bad,’” (p. 28). With this script being given, men are encouraged to overcome “good” women by using the right words, the right moment, or the right mood in order to respond sexually. When a “bad” woman takes on the traditionally stereotypical male role, the scripts are turned upside-down. No one knows what to do with that. Like the woman of the nineteenth century who had more sexual desire than her husband, the millennial female with sexual addiction is labeled “bad”. Again, this is counter to Adler’s beliefs about equality as a foundation for relational intimacy.

**Female addiction presentations.** As mentioned in the description of sexual addiction, females with sexual addiction display specific presentations: relationship or love, romance, fantasy, pornography or cybersex, masturbation, exhibitionism, selling or trading sex, or partnering with another addict (Ferree, 2010). Relationship addicts are women who are involved in serial or simultaneous relationships, or either short-term or long-term affairs (Ferree, 2010; Ferree, 2001). Often hooked on unavailable people, the obsession often reaches a point that makes daily life tasks unmanageable (McDanile & Valenti-Anderson, 2012). The relational pull is stronger than the sexual one. These women believe a relationship is their most important need, and many have never experienced a season of abstinence from romantic or sexual relationships (Ferree, 2001).

The Romance Addict is a woman who is interested in the chase (Ferree, 2010). Pursuing and being pursued are her goals, and she believes that her ultimate happiness will come with a romantic relationship. This, however, is one of her mistaken beliefs. She wants the payoff of a fulfilling relationship, so she pursues the connection. However, she isn’t interested in the work that comes after a connection is made, fearing her inferiorities will be discovered and she will be forced to confront them with her new partner. When the desired object of affection is attained,
the high fades, the fears grow, and the relationship comes to an end. The Romance Addict continues a pattern of self-doubt followed by a need for frequent reassurance of being chosen. Similarly, the Fantasy Addict desires the high of romance, however her relationships take place in her head. Obsessing about a man she has seen in a public place, or a man she works with or lives near, the Fantasy Addict focuses her life on the fantasy man, not reality. This offers her an escape from her boring life, but offers none of the true rewards. She is often not able to experience the joy of real moments due to her obsession with her fantasy life. The same can happen with those engaging in cyber-fantasy or cyber-relationships.

The Pornography or Cybersex Addict presentation has grown with the rise of the Internet (Ferree, 2001). Primarily among young women who have grown up in a media-saturated culture, the Internet has been called the crack cocaine of sex addiction because of its “accessibility, affordability and anonymity” (Ferree, 2010, p. 62). For the female with sexual addiction, use of pornography and cybersex is still more relational than sexual. Though once thought to be a small part of females’ addictive patterns, reports discussed by Ferree (2010) showed one in three visitors to adult websites to be female. This particular presentation, use of pornography, brings additional shame because it doesn’t fit the stereotypical relationship presentation of women. Perhaps the high of a woman’s masculine protest finds tension with her need to find belonging, even if that belonging is in the expression of her problem.

Masturbation is also a primary presentation for females with sexual addiction (Ferree, 2010). Though often brought on by the introduction to sexual responses by abuse at a young age, or through healthy self-exploration that becomes habitual, masturbation is primarily used to alter a female’s mood in an unhealthy way. She may never look at pornography or be physically
sexual with another person, but the female who uses masturbation compulsively may be escaping her problems, soothing herself, or avoiding true intimacy with her partner.

Because our culture seems to condone female exhibitionism, as evidenced by cultural practices such as Mardi Gras and videos such as *Girls Gone Wild*, exhibitionism as a sexual addiction presentation can be difficult to prescribe (Ferree, 2010). Strippers and pornography actresses would be considered exhibitionists, as well as those who flash themselves in public for a little attention. Though these females are objectifying themselves, the emotional high they feel from the attention they receive often trumps the pending wounds to her self-esteem. This high is not long lasting, however, and the wounds are often deepened. The accompanying shame and guilt that come only perpetuate the addiction cycle. Another way in which women objectify themselves is by selling or trading sex. This presentation doesn’t just apply to prostitutes, but also to women who provide sex in order to have a favor offered, a pattern of quid pro quo.

The co-addict has been the primary presentation focused on when treating females in the field of sexual addiction (Ferree, 2010). As has been shown, however, a woman is just as susceptible to being the addict herself as the man she is with. Switching between being the addict and the co-addict, a women partnering with another addict is in for a confusing and volatile relationship. Looking at the motivation behind each experience can give insight to the differentiation between these two roles. Equally confusing is the presentation of sexual anorexia.

Similar to the eating disorder spectrum, the sexual anorexic thrives on her aversion to sexual activity (Ferree, 2010; Ferree, 2001; Carnes, 1997). She likely is unaware of how much effort she puts into avoiding anything sexual, and thus may not believe she has a problem (Ferree, 2001). For the sexual anorexic, however, distortions of body image and shame about her body or sexual experiences (including abuse) cause her to cycle between the dread of sexual
pleasure and a compulsive avoidance of sex (Ferree, 2010; Carnes, 1997). This presentation may also be part of a binge/purge-cycle for some female addicts. Sex may move from being her most terrifying need to her most important.

Though many fear their sexual behavior being blamed on an innate neediness, the female sex addict is primarily motivated by power and loneliness (Ferree, 2001). In her attempt to resolve her wounds of neglect and/or abuse, the female with a sexual addiction is determined to “be in control, to avoid being hurt, [and] to be in a one-up position,” (p. 294). Her behavior is driven by her mistaken beliefs and her goal of guarding her inferiorities. Her desire to be found secure, significant, and part of the whole, may move her to act as the powerful or seductive siren. Sex may be the only substitute she knows for love.

**Trauma-informed treatment.** As mentioned by Schneider et al., (2005), many women with poly-addiction, suffer from PTSD. Reports have shown that up to 90% of public mental health clients have been exposed to or have experienced trauma (Goodman, Rosenberg, Mueser, et al., 1997 as cited in Rosenberg, 2011). Trauma can include a wide range of experiences, including: experiencing neglect, surviving emotional or physical abuse, surviving sexual assault, witnessing domestic violence, or experiencing war (Rosenberg, 2011; Marich, 2010; Covington, Burke, Keaton & Norcott, 2008).

As cited in Marich (2010), Shapiro (2001) believes that “trauma” need not fit the diagnostic criteria found in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*). Depending on the individual's lifestyle, and thus, guiding fictions, surviving war combat (a Criterion A trauma according to the *DSM-IV-TR*) may be as problematic as growing up in an emotionally abusive home (not a clear Criterion A trauma). The individual will follow whatever guiding beliefs help him or her to safeguard. For the female client, this is
particularly important. Though both men and women alike experience trauma, there has been a strong link identified between “victimization [and] traumatization in women and substance abuse or dependence disorders,” (Grella 2003; and Najavits, Weiss & Shaw, 1997 as cited in Covington et al., 2008, p. 388). In terms of substance addiction treatment, trauma-informed care is now the expectation, and no longer the exception (Rosenberg, 2011). Several of the above mentioned authors have commented on the role trauma plays in the etiology of sexual addiction (Salisbury, 2008; Briken et al., 2007; Del Giudice & Kutinsky, 2007; Klontz et al., 2005). Many have also looked to substance addiction treatment to inform their sexual addiction treatment methods (Hardy et al., 2010; Hagedorn, 2009; Hagedorn & Juhnke, 2005). Using a trauma-informed treatment model for women with sexual addictions may prove as beneficial as it has in treatment for women with substance addictions.

In 2004, funding was acquired to offer trauma-informed treatment services to a group of women in a 12-month, residential drug and alcohol treatment program (Covington et al., 2008). Seventy-three women were taken through two phases of manualized curriculum developed by Dr. Stephanie Covington. This material was developed with a focus on “gender responsiveness” (Covington and Bloom, 2006, as cited in Covington et al., 2008). Gender responsiveness is defined as, “creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's and girls' lives and is responsive to their strengths and challenges,” (p. 390).

Phase one of Dr. Covington's program, Helping Women Recover: A Program for Treating Addiction, focused on treating women with histories of addiction and trauma. Based in theories of addiction, trauma, and women's psychology, this curriculum utilized psychoeducation, cognitive-behavioral, expressive arts, and relational approaches. Phase two,
Beyond Trauma: A Healing Journey for Women, focused specifically on trauma. Psychoeducation, CBT, and expressive arts were again utilized, with major emphasis on violence, abuse and trauma, the impact of trauma, and healing from trauma.

Over the 12-month program, participants were assessed at five time points (Covington et al., 2008). Along the way, assessments included areas of sociodemographic characteristics, trauma, depression, criminal activity and current drug use, and client satisfaction. The results suggested that continued improvement was made over the course of treatment. Trauma and depression symptomology both showed clinically significant decreases, as well as significant decreases in sleep disturbances and anxiety.

In the assessment on client satisfaction, 92% rated their experience as either “very positive” or “positive” (Covington et al., 2008). “Clients overwhelmingly felt better about their emotional and physical health after participation in the program,” (p. 395). Reasons for their positive responses included: the opportunity to grow and become familiar with oneself (41%), support/unity (36%), and the structure and tools learned (16%). These elements echo some of Yalom’s therapeutic factors described by Nerengerg (2000) in regards to group therapy. Though the sample of women studied was a sample of convenience, and the study lacked a comparison group, the results lend themselves to growing evidence of the importance of integrating trauma-informed methods to dual-diagnosis treatment.

Marich (2010) also believes in the importance of trauma-informed care, and describes how the use of Eye Movement Desensitization and Reprocessing (EMDR) can be beneficial in recovery. Marich shares Ferree et al.’s (2012) view that traditional care methods beneficial for men, may not be beneficial for women. She argues that traditional methods of addiction treatment (12-step/Minnesota Model and CBT) “tend to marginalize addicted, traumatized
women more than they do their male counterparts,” (Marich, 2010, p. 498). Because women have more tendencies towards poor self-efficacy, negative emotions and poor coping skills, a treatment that combines cognitive, body-oriented, emotional, and experiential matter is better suited. Marich suggests EMDR does just this. In a case following a 21-year-old sexually addicted female, Cox and Howard (2007) show a positive response to EMDR over 15 sessions. EMDR and other trauma-informed treatments, focus on core traumatic memories. This positively impacts the client's use of relapse prevention skills, perhaps by bringing resolution to these early recollections and providing framework for reframed beliefs (Marich, 2010; Covington et al., 2008; Cox & Howard, 2007).

**Females seeking treatment.** Many females have the mistaken belief that they are alone in their behaviors (Ferree, 2001). This is because most are afraid to talk about their struggles, fearing being shamed by others who do not understand. Many women would much rather be considered co-dependent or relationally addicted, even considered a victim, than be labeled sexually addicted (McDanile, & Vanelti-Anderson, 2012; Ferree, 2001). Because of this, many never seek treatment, and the emotional and circumstantial consequences of their struggle needlessly continue. Awareness and insight is never given to their mistaken beliefs and thus reframing and healing is not gained.

Consequences for the female with sexual addiction are much the same as their male counterpart, however, there are a few additional consequences of great importance, including sexually transmitted diseases, which may lead to cervical cancer, and unwanted. Between 25% and 50% of women, with sexual addiction, have had at least one abortion due to unwanted pregnancy following their addictive behaviors. If the woman is a wife or mother, unique impacts on her family occur as well. For her children, she may even be unconsciously perpetuating a
cycle of psychological neglect, which could lead to mistaken beliefs and safeguarding behavior in her children.

When a female does choose to enter treatment, assessment and diagnosis become a part of the journey. When assessing women for sexual addiction, the following have been described as “must be” considered and included in the assessment: the unique presentations of sexual addiction in women, relationship patterns and sexual activity, language that females relate to that targets their experiences, and power motivations (Ferree, 2010). At the time of her 2010 article, *Females and Sex Addiction: Myths and Diagnostic Implications*, Ferree recommended starting with the Women’s Sexual Addiction Screening Test (W-SAST) developed by Carnes and O’Hara. Available through the Sexual Recovery Institute’s website, the W-SAST consists of 25 questions and provides “a profile of responses which help to identify women with sexually addictive disorders,” (Sexual Recovery Institute, 2013). After assessing, one must then make some decisions about diagnosis.

When diagnosing sexual addiction in women, several presentations are often missed (Ferree, 2001). Relationship addiction, for example, gets missed because it is outside the paradigm of typical male presentations. Diagnostic instruments and assessments that only offer questions about sexual behavior, per se, miss the obsessional nature of this presentation for women. These tools also fail to identify many women whose presentation does not seem as destructive as other presentations. Because of the relationally driven nature of sexual addiction for females, pornography or cybersex addicts may be overlooked based on her preferring chat rooms to pornography. For the female with sexual anorexia, the woman herself may not recognize a problem, and therefore may need her therapist to bring sexuality up in the first place.
Taking into consideration that the descriptions of these presentations are umbrella statements, this writer must acknowledge that every client will present uniquely. Assessment and diagnosis may not be relevant for each client. Her story and Life Style will be as unique and creative as her presentation, and her treatment must be equally unique.

**Universal Standard?**

With ever decreasing cultural boundaries and increased globalization, a universal standard of what it means to be a woman seems impossible. The social script of women is so varied across ethnocultural boundaries, not to mention interpersonal differences, including: gender identity, age and generational identity, social class, education level, professional identity, and religious identity. To assume one standardized treatment modality to be sufficient for all women is just as limited a view as assuming male treatment modalities should work universally for all women (or all men for that matter). While gender-neutral approaches neglect the unique needs of women, silo treatment modalities for western white females with sexual addiction will also create treatment exclusion. Creating and utilizing standardized assessments and treatment modalities is an important part of the journey to healing for the female with sexual addiction, but her unique context and experiences must be taken into consideration. Because of this, the Adlerian Life Style assessment seems like an appropriate place to start.

The Adlerian Life Style assessment takes into consideration unique nuances of an individual’s life. For a woman with a sexual addiction, her family map, or genogram, may help uncover specific relationships worth exploring, or generational addictions, relational conflicts, or mental health problems. Understanding her place in birth order and the characteristics of each sibling, including how each child related to each parent, would help uncover the client’s perception of how she fits into her world. This assessment would help shape the course of
treatment by first understanding her mistaken beliefs, perhaps through the use of Early Recollections, and the roots of or reasons for her symptoms. As Satir’s Ice-Berg Model suggests, the problem is not the problem (Satir et al., 1991 as cited in Laaser, 2008). The sexual acting out or in is merely a symptom of a deeper pain that needs healing or distortion that needs clearing up.

When a woman has come to therapy, ready to discuss her addiction to sexual behaviors, she is behaving in a way that says she is ready to own responsibility for her actions. This is counter to self-justifications humans often find themselves in. Men and women alike can be found to prefer freedom from responsibility. Engaging the client in an I-Thou manner will help build the therapeutic relationship, and help the female with a sexual addiction let down her suspicions about treatment. It may also help her to feel confident in her ability to take responsibility as the client. Maintaining a balance of client and therapist responsibility is important when working with sexually addicted clients, as the following will describe.

**Ethical Issues**

As this paper shows, there are many variables to sexual addiction that make working with this population complex. There is a high possibility of the client suffering from multiple addictions, compulsive behaviors, or comorbid emotional or personality disorders, not to mention a history of trauma, faulty attachment styles and/or a deficiency in one’s capacity to be intimate. These variables all add to the possibility of ethical issues arising. For example, the length of treatment, which can be up to 8 years depending on the severity, also adds potential questions to the process (Carnes, 1989 as cited in Griffin-Shelley, 2009). The average length of treatment for traditional mental health is about six sessions. If someone finds themselves in treatment for 8 years, questions about usefulness of treatment or motive of therapist may surface.
Below is a list of additional issues the sexual addiction therapist would benefit from paying attention to (Griffin-Shelley, 2009):

- **The Therapist’s Personal Needs & Competency** – Knowing your scope of competency, and your capacity for exploiting or victimizing the client, as the therapist, is very important with this population. If the therapist is unable to freely talk about areas of sexuality, trauma, or other components of this problem, the client may receive more harm than help in session.

- **Self-Disclosure** – The sexual addiction therapist must pay attention to whose benefit the disclosure is for. It needs to be for the client’s.

- **Reenactment of the Client’s Trauma in the Therapeutic Relationship** – These clients have been exploited, shamed and humiliated. They do not want to be again. The therapist can be seen as the abuser for many reasons and must look for signs of this happening.

- **Boundary Issues** – This population of client tends to come from relationally dysfunctional families, either too distant, or too enmeshed. Questions around expectations, suggestions, or direction can surface from the client if these areas are not openly discussed. Because this population is still learning what healthy relationships look like, it is also important to seek consultation with other therapists when any questions about relational boundaries surface. Codependency can happen when the therapist begins doing too much or being loose about boundaries.

  Group therapy also has the potential to create boundary issues between clients. This population seeks healing in community, and, again, because they are still learning what healthy relationships look like, conflict can arise between members as well.
• Dual Relationships – Because many females with sexual addictions participate in both individual and group therapy, as well as the possibility of support groups, the chance that the individual therapist would serve in multiple roles is high. Also, the therapist may play the role of an advocate for the client if a third party is involved. Keeping healthy boundaries between each role as well as seeking consultation when appropriate will help with navigation through the multiple roles a sexual addictions therapist may be in.

• Blindness to Pathology – assessing for additional diagnostic problems is often overlooked if the focus is too strongly on the addiction. Self-centeredness, depression, and mood swings may not disappear with sobriety. Paying attention to these changes and lack of changes will help rule-out additional diagnoses.

• Over-Pathologizing – Like the risk of being blind to pathology, some therapists may also exaggerate a client’s problems. This is often to fulfill a need of the therapist and not the client.

• Difference of Values – Knowing who the intended beneficiary is within the therapeutic relationship will help when differences of values arise.

• Emotions – Anger, abandonment, attraction, and fear are also things to be watching for in the client as well as in the self of the therapist. Un-dealt-with emotions in the therapist can be just as harmful to the client as their problems are.

The list of ethical issues to be on the lookout for is much longer than the above list, and the conversations surrounding these issues much broader. The scope of this paper is not to unearth them all, but to give awareness to the most basic issues operating within the complexity of working with this population. Ongoing training and intentional dialogue with others in the
same channel of work can give the sexual addictions therapist clearer eyes to see ethical pitfalls, and additional opportunities to offer successful treatment to the client with sexual addiction.

Conclusion

Treatment for sexual addiction has been seen to include a combination of group, individual and couples therapy, and the use of 12-Step groups or spiritual communities. Theories and techniques may be rooted in CBT, Gestalt, Expressive therapies, psycho-pharmaceuticals, etc. It is clear from the lack of empirical research contained in the above review, that the call for further research in the field of sexual addiction treatment, in general, is an understatement. Not just reports of clinical experience, but empirical research, using standardized testing methods, producing statistically significant outcome data is needed. When one considers the additional component of gender-responsive treatment for sexually addicted females, the surface hasn't even been scratched.

As a future clinician, this writer hopes to offer a specialization in female sexual addiction treatment. Rooted in the above research, and guided by those working in the field, including Mark and Debbie Laaser, and Marnie Ferree, this writer’s work will be influenced by contemporaries in an age-old field. Integrating Adlerian knowledge and tools into this research will be a challenge this writer is excited to take on.

In a spirit of social interest, this writer also sees the need for a change in our culture’s perception of women. The Dr. Jekyll and Mrs. Hyde woman, the monstrous feminine made flesh, is not the legacy she wishes to perpetuate. This writer hopes to offer women alternative scripts besides saint or slut. Preventative strategies through community education and clinical research need to be a part of this journey. Our culture needs healing as much as these women, and this writer is anxious to join the effort.
Appendix

The following is a series of Tables and Figures referred to in the body of this paper. These documents provide condensed, visual alternatives to some of the information described. They have not only been a part of this writer’s understanding of the above academic work, but have become quick references for this writer in her clinical work as well. Her hope is that others may find these resources equally as useful.

Included, the reader will find: (Figure 1) the Addiction Cycle/System with notes about how Adlerian theory fits in, (Table 1) a detailed description of Hagedorn’s Six-Factors of Competency for the sexual addiction counselor, (Table 2) Patrick Carnes’ 30 Tasks of Recovery, (Table 3) the Twelve Steps of Sexual Addicts Anonymous, (Figure 2) Mark Laaser’s adaptation of Virginia Satir’s Iceberg Model, and (Figure 3) Mark Laaser’s Five Components of Treatment.
Figure 1: The Addiction Cycle within the Addictive System

Belief System = Life Style:
Contains faulty assumptions, myths & values

Impaired Thinking = Mistaken Beliefs

Addiction Cycle - All cycles of behavior can fit in this space. Each cycle impacts all others. Toxic cycles infect all others just as healthy cycles can heal others.

Unmanageability continues the distortion of the belief system and the cycle continues

Unmanageability is the product of collected evidence of the mistaken beliefs

Unmanageability

Impaired Thinking

Addiction Cycle

Preoccupation/Fantasy

Despair

Ritualization

Acting Out
(Sexual Compulsivity)
Table 1: Hagedorn's Six-Factors of Sexual Addiction Counseling Competency (Hagedorn, 2009)

**Factor 1 – Family Counseling Interventions**

- Establish rapport with family and significant others.
- Clarify family counseling goals.
- Work with and engage co-sex addicts.
- Counsel significant others concerning sexual addiction.
- Inform family of family dynamics/roles.
- Interview client's family and/or significant other(s).
- Develop family conflict resolution strategies.
- Provide individual/group and/or crisis counseling for client/family members related to sexual addiction.
- Use group-centered group counseling techniques.
- Determine necessity for an intervention related to sexual addiction.

**Factor 2 – Pre-treatment Interventions**

- Evaluate client intake data.
- Evaluate existing (pre-counseling) client data.
- Obtain client medical history.
- Apply ethical or Federal counseling legal standards.
- Conduct mental status examination.
- Evaluate client need for further assessment.
- Determine appropriate DSM-IV classifications.
- Assess potential for client to harm self/others.
- Determine appropriate level of care according to the American Society of Addiction Medicine.
- Assess match between client's needs and program services.
- Obtain client consent before initiating treatment.
- Provide other resources if not admitted.

*(Continued on next page)*
Factor 3 – Sexual Addiction Assessment Interventions

- Conduct pretreatment sexual addiction diagnostic interview.
- Administer sexual addiction assessments.
- Determine signs and symptoms of psychological withdrawal from sexual addiction.
- Use non-test appraisal techniques for sexual addiction.
- Determine severity of client's sexual addiction problem.
- Discuss client's reasons for seeking treatment for sexual addiction.

Factor 4 – Sexual Addiction Specialty Counseling

- Provide client with education concerning cross addiction.
- Provide client with education concerning addiction interaction disorder.
- Process 12-step assignments related to sexual addiction.
- Educate client about different types of addiction (chemical and process).
- Educate client about self-help groups for sexual addiction.
- Address client denial of sexual addiction.
- Counsel client regarding defense mechanisms.
- Educate client about “traumatic bonding,” the process whereby abuse victims form a dysfunctional attachment that occurs in the presence of danger, shame, or exploitation.
- Reframe client's problems.
- Assess client's family history of addictive disorders.
- Provided impetus for client to remain in treatment.
- Provide counseling for the dually-diagnosed client.
- Use cognitive-oriented counseling techniques.

Factor 5 – Treatment Planning

- Evaluate client's movement toward counseling goals.
- Evaluate progress toward treatment goals.

(Continued on next page)
• Assist client in setting short-term and long-term goals.
• Assist client in evaluation of progress in treatment.
• Construct comprehensive care/treatment plans including goals, objectives, strategies, time frame, discharge, and aftercare plans.
• Establish counseling goals and objectives.
• Prepare client for termination from counseling.
• Co-construct comprehensive treatment plans.
• Function as a member of an interdisciplinary treatment team.

Factor 6- Professional Practice
• Use prevention measures to guard against counselor burn-out.
• Participate in personal and professional development (e.g., review ethics, read current professional literature, attend seminars).
• Recognize and examine clinician’s own biases.
• Collaborate with referral systems.
• Recognize and examine clinician’s own sexuality.
• Inform client about ethical standards and practice.
• Observe client for medication side-effects (if appropriate).
Table 2: Tasks of Recovery developed by Patrick Carnes, Ph.D. (Carnes, 2001)

<table>
<thead>
<tr>
<th>Task/Goal</th>
<th>Performable</th>
<th>Life Competency</th>
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</table>
| 1. Break through denial. | • Creates a problem list  
• Records a secret list  
• Completes list of excuses  
• Completes Consequences Inventory  
• Learns 14 ways to distort reality  
• Inventories 14 distortion strategies in personal life  
• Accountability – Victim Empathy Exercise  
• Makes full disclosure to therapist | • Understands the characteristics of denial & self-delusion  
• Identifies presence of self-delusion in life  
• Knows personal preferred patterns of thought distortion  
• Accepts confrontation |
| 2. Understand the nature of addictive illness. | • Completes assigned readings on sex addiction.  
• Learns different ways to define sex addiction  
• Understands addictive system  
• Understands deprivation system  
• Maps out personal addictive system  
• Understands criteria for addictive illness  
• Applies criteria to personal behavior  
• Learns key factors in the genesis of sex addiction  
• Understands sexual modularity  
• Understands sexual hierarchy  
• Knows ten types of behavior | • Knows information on addictive illness  
• Applies information to personal life |

Sexual Addiction Component
| **Sexual Addiction Component**<br>*(Continued)* | • Reviews ten types for personal patterns  
• Understands stages of courtship  
• Reviews personal courtship patterns  
• Matches courtship patterns with acting out patterns | • Understands courtship patterns & intimacy issues |
|---|---|---|
| 3. Surrenders Process. | • Understands context of change, grief, commitment  
• Understands existential position on change – essence of recovery  
• Understands principles of anxiety reduction  
• Completes sexual addiction history  
• Completes powerless inventory  
• Completes unmanageability inventory  
• Completes financial costs inventory  
• Identifies ten worst moments  
• Understands guidelines of step completion  
• Gives First Step | • Acceptance of addiction in life  
• Knows personal limitations  
• Discerns difference between control label & non-controllable events |
| 4. Limit damage from behavior. | • Understands 1st & 2nd order change  
• Understands concept of paradigm shift  
• Records provisional beliefs  
• Completes damage control plan  
• Completes a disclosure plan  
• Completes a Second & Third Step | • Integrates self-limitation into personal paradigm  
• Responds to crisis plan fully  
• Uses boundaries at a minimum level  
• Has internal skills for anxiety reduction |
### 4. Limit damage from behavior. (Continued)
- Develops resolve for change & commitment

### 5. Establish Sobriety.
- Understands sobriety as boundary problem
- Understands sobriety challenge
- Completes recovery essentials exercise
- Completes sobriety challenges worksheet
- Writes sobriety statement including
  - abstinence list
  - boundaries list
  - sexual health plan
- Understands relapse process
- Completes Relapse Prevention sequence including
  - fire drill planning
  - letter to self
  - emergency first aid kit
  - relapse contract
  - celibacy contract
- Establishes a date
- Uses clearly stated boundaries of sobriety
- Manages life without dysfunctional sexual behavior

### 6. Ensure Physical Integrity.
- Learns physical aspects of addiction
- Learn about sexually transmitted diseases
- Completes physical
- Completes psychiatric assessment
- Learns neuropathways of addiction
- Uses clearly stated boundaries of sobriety
- Manages life without dysfunctional sexual behavior
6. Ensure Physical Integrity. (Continued)
   - Learns sexual neuropathways
   - Learns sexual addiction matrix
   - Completes matrix exercise
   - Understands arousal template
   - Maps personal arousal template including
     o fantasy worksheets
     o arousal template worksheets
     o drawing decision tree

7. Participate in a culture of support.
   - Participates in a 12-Step program
   - Knows different fellowships
   - Develops relationship with sponsor
   - Participates in program life
   - Presents Steps in program
   - Does service in program
   - Knows signs of a healthy group
   - Has celebration date
   - Completes important people inventory
   - Maintains a healthy support system
   - Knows differences in fellowships
   - Maintains relationship with members of recovery community
   - Knowledge of 12-Step work
   - Knows signs of healthy support group
   - Uses steps “therapeutically”
   - Understands control/anxiety paradigm of 12-Step life

8. Reduce Shame.
   - Complete Step 4 and Step 5.
   - Recognize and manage toxic shame.

   - Define clear grieving strategies and use them.
   - Recognize grief and have skills for grieving.

(Continued on next page)
| 10. Understand multiple addictions & sobriety. | • Complete an Addiction Interaction Disorder screen.  
• Complete a Multiple Addiction Relapse Prevention Plan. | • Remain relapse free from all concurrent addictions. |
|---|---|---|
| 11. Acknowledge cycles of abuse. | • Complete Survivors weeks.  
• Complete Abuse Inventory. | • Identify abuse & exploitation. |
| 13. Restore financial viability. | • Live within financial means (spend less than earned)  
• Work a recovery financial plan | • Maintain financial viability. |
| 14. Restore meaningful work. | • Establish a meaningful career path. | • Have meaningful work. |
| 15. Create lifestyle balance. | • Use a Personal Craziness Index for 8 weeks. | • Live in balance & harmony. |
| 16. Build supportive personal relationships. | • Find and use a sponsor.  
• Attend therapy group for 175 hours.  
• Be a sponsor to others. | • Initiate & sustain enduring life relationships. |
| 17. Establish healthy exercise & nutrition patterns. | • Have a weekly aerobic exercise pattern.  
• Remain in appropriate weight range for age & height. | • Stay physically fit. |

(Continued on next page)
| 18. Restructure relationship with self. | - Complete eighteen months of individual therapy.  
- Clarify boundaries, goals & needs. | - Have a workable, compassionate relationship with self in order to be self-determining & autonomous. |
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<tr>
<td>19. Resolve original conflicts-wounds.</td>
<td>- Do therapy specific to family of origin or trauma issues.</td>
<td>- Identify &amp; manage recurring dysfunctional patterns.</td>
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| 21. Involve family members in therapy. | - Family members attend Family Week.  
- Family members attend therapy sessions. | - Capacity to ask help from immediate family.                   |
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<td>22. Alter dysfunctional family relationships.</td>
<td>- Full disclosure to primary partner &amp; immediate family as appropriate.</td>
<td>- Remain true to self in the presence of dysfunction.</td>
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<td>23. Commit to recovery for each family member.</td>
<td>- Family members enter a recovery program for themselves.</td>
<td>- Take responsibility for self.</td>
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<td>24. Resolve issues with children.</td>
<td>- Share secrets &amp; make amends to children when appropriate.</td>
<td>- Resolve conflict in dependent relationships.</td>
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<tr>
<td>25. Resolve issues with extended family.</td>
<td>- Share secrets &amp; make amends to extended family when appropriate.</td>
<td>- Resolve conflict in interdependent relationships.</td>
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<tr>
<td>27. Recommit/commit to primary relationship.</td>
<td>- Commit to a primary relationship, or recommite to primary relationship.</td>
<td>- Capacity to maintain a committed relationship.</td>
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<td>28. Commit to coupleship.</td>
<td>• Attend Twelve Step meeting for couples regularly.</td>
<td>• Participate in a community of couples.</td>
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<tr>
<td>29. Succeed in primary intimacy.</td>
<td>• Have a primary relationship, which is satisfying.</td>
<td>• Be vulnerable &amp; intimate.</td>
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<td>30. Develop a spiritual life.</td>
<td>• Find and use a spiritual director or mentor.</td>
<td>• Be spiritually conscious.</td>
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<td>• Join a spiritual community.</td>
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Table 3: The Twelve Steps of Alcoholics Anonymous Adapted for Sexual Addicts (Carnes, 2001)

1. We admitted we were powerless over our sexual addiction – that our lives had become unmanageable.
2. Came to believe a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to others and to practice these principles in all our affairs.
Figure 2: The Iceberg Model (Laaser, 2008)

Behaviors/Problems

Coping
Relationship stances Individual coping
(placater, blamer, super-strategies
reasonable, irrelevant)

Feelings
joy, excitement, anger, hurt, fear, sadness

Feelings about Feelings
The decisions we make about our feelings

Perceptions, Meanings, and Core Beliefs
Internal messages

Expectations
Of self, of others, from others and of life

Yearnings
(Laaser’s Seven Desires of the Heart)
To be heard, affirmed, blessed, safe,
touched, chosen, included

Reclaiming
The Truth about Ourselves
“Fearfully, and wonderfully made,” God within
Figure 3: Laaser’s Five Components of Treatment (Laaser, 2004)

**Healing Shame**
- Confession of sin & repentance
- Practicing spiritual disciplines
- Healing trauma
- Belonging to an affirming church and social community

**Stopping Fantasy**
- Understand the 3 objectives of fantasy
- Discover what the fantasies symbolize & what needs of the wounded self they represent

**Healing Despair**
- Finding God
- Asking for forgiveness
- Admitting being out of control
- Affirmations from others
- Hearing the stories of others

**Stopping Rituals**
- Identify ritual behaviors
- Establish roadblocks
- Develop healthy emotional, physical, & spiritual rituals

**Stopping Sexual Behaviors**
- Abstinence contract
- Accountability plan
- Counseling
- Medical help
- Outpatient & intensive programs
- Inpatient treatment
References


