CONTINUING EDUCATION (CE) COURSE MATERIAL
Course No. CE1309 – Sexual Addiction

COURSE OBJECTIVE

An introduction to the study of sexual addiction, especially inappropriate and obsessive sex, and an overview of the physiological, societal, commercial and environmental effects of this type of activity.

COURSE MATERIAL

Consequences of Sex Addiction and Compulsivity[1]
from The National Council on Sexual Addiction and Compulsivity

Compulsive sexual thoughts and/or behavior lead to increasingly serious consequences, in both the addict's internal and external worlds.

The consequences may include severe depression, often with suicidal ideation, low self-esteem, shame, self-hatred, hopelessness, despair, helplessness, intense anxiety, loneliness, moral conflict, contradictions between ethical values and behaviors, fear of abandonment, spiritual bankruptcy, distorted thinking, remorse, and self-deceit.

For example, 70-75 percent of addicts have thought about suicide. Many sex addicts suffer from broken relationships. Forty percent experience severe marital and other relationship problems. Sexual activities outside the primary relationship result in loss of self-esteem to both partners as well as severe stress to the relationship. The sex addict is frequently absent, resulting in a loss of time in parental role modeling. Pressure is
placed on the partner to provide parental support and nurturing of the children.

Partners of sex addicts may develop their own addictions and compulsions, psychosomatic problems, or depression and other emotional difficulties.

These factors can result in an unstable family environment. Physical, sexual, and/or emotional abuse and neglect of the children may occur. In one study, 72% had been physically abused in childhood, 81% had been sexually abused, and 97% emotionally abused. Growing up in such a home increases the risk for the next generation to have addictive disorders.

Health consequences of sex addiction may include HIV infection, genital Herpes, syphilis, gonorrhea, and other sexually transmitted diseases (STDs).

Sex addicts have an increased risk of STDs. Genital injury may result from excessive sexual activity or the use of sex aids and foreign objects. Addictive sadomasochistic sex can lead to physical damage to the body. Automobile accidents can result when sexual activity causes the driver's attention to stray.

Some sex addicts go to jail, lose their job, get sued, or have other financial and legal consequences because of their compulsive sexual behavior.

[1] This and other excellent articles are available on-line at The National Council on Sexual Addiction and Compulsivity (NCSAC) web site, located at www.ncsac.org.

Financial difficulties from the purchase of pornographic materials, use of prostitutes and telephone and computer lines, travel for the purpose of sexual contacts, and other sexual activities can tax the addict's financial resources, sometimes to the point of bankruptcy, as can the expenses of legal representation.

Sixty percent of addicts have faced financial difficulties, 58% engaged in illegal activities, and 83% of sex addicts also had concurrent addictions such as alcoholism, eating disorders, or compulsive gambling.

Legal consequences of sexual addiction result when illegal behaviors such as voyeurism, exhibitionism, or inappropriate touching, result in arrest and incarceration.

Child molesting and rape in some cases are addictive behaviors. Sexual harassment in the workplace can be part of a sex addict's repertoire, and may result in legal difficulties on the job.

Over half the cases of sexual exploitation by professionals are perpetrated by sex addicts. Churches and synagogues are being subjected to greater scrutiny as more clergy are charged with some form of sexually inappropriate behavior. Sexual misconduct by licensed professionals (including physicians, therapists, clergy, and lawyers) result in loss of license, academic standing, and reputations, and victimization of those people they are mandated to help.

Many sex addicts are also addicted to alcohol and other drugs. When multiple addictions coexist, untreated sex addiction complicates recovery from chemical dependency and makes relapse to drug use more likely.

Both men and women are objectified, and therefore placed at greater risk to be victimized, in a society which provides many services to sex addicts and which uses women as sex objects in advertising to sell automobiles, liquor, and other products.

This promotes an attitude that sex is the answer to many problems.

The physical, emotional, spiritual, financial, legal, and family consequences of sex addiction demand that we pay greater attention to this widespread problem.

NCSAC wishes to thank Dr. Ralph Earle and Dr. Marcus Earle for their contributions to this position paper.

Intervention and the Sexually Compulsive Patient
by James Fearing, Ph.D., C.C.D.P.

There are many unique clinical challenges and complexities faced by the therapist or professional interventionist when intervening the sexually compulsive/sexually addicted patient. Important awareness regarding the painful impact and destruction consistent with this compulsive disorder has grown dramatically throughout this past decade.

The clinical research and associated information brought forth has precipitated a need for further development, distribution and implementation of the appropriate intervention strategies and/or treatment processes. An important question often asked is; "Should a professional intervention be planned if the sexually compulsive
patient is acting out, and he or she is in denial?"

Due to the combination of social sensitivity and the existing negative public perceptions associated with sexually addictive behaviors, it has not been an easy field for which to enlist outside support. At times, it has been treated more like a "hot potato," which only gets handled when there is no possible way to avoid it. Unfortunately, the deep shame that accompanies this disorder, combined with the denial factor, sets up a psychological barrier that blocks the sexually compulsive person from asking for help.

In evaluating the clinical integrity of providing professional intervention in this area, this dynamic provides insight. In some cases there may be no other possibilities for the suffering sex addict to receive help other than intervention.

Similarities with Other Addictions
Individuals who suffer from sexual compulsivity/sexual addiction may display many symptoms similar to those of people affected with other addictions. Until recently, this disorder remained in the background for many healthcare providers as well as the general public. Today, more people understand those who are affected by this disorder. People are witnessing the extreme emotional pain, physical health risks, destroyed careers and deep shame associated with sexually compulsive behavior. Unfortunately, it has taken high-profile cases such as Hollywood celebrities, professional athletes, TV evangelists and national politicians to gain the needed attention. It is still commonplace for the media to misrepresent sexually compulsive behavior. It is primarily masked or camouflaged as bad boy/bad girl behavior. Seldom is it reported as an addiction or obsessive-compulsive disorder within the disease concept. Due to sensationalized reporting practices, the focal point never reaches past the scandal or problem, and therefore never accurately discusses the illness and treatment.

There are many similarities between sexual addictive behavior and the more commonly treated addictions. One commonality seen in all addictive behavior is an attitude of denial, combined with the continuous demonstration of a "loss of control." This loss of control is present regardless of the painful, negative consequences experienced when acting out this compulsive behavior. This produces the dynamic of feeling powerless, extreme mood swings and painful isolation. It is not uncommon to hear a patient describe the "rush" that is experienced prior to and during the compulsive behaviors as somewhat like the effect of getting high on drugs. The person often feels a physiological change within him or herself that many times ends in a severe let-down or depression.

The Shame-Based Disease
One of the most predominant features consistently experienced by the sexually addicted person is the presence of overwhelming shame. While shame, to some degree, is a common characteristic found in all addictions, this specific disorder is fully cloaked and grounded in shame. At a deep emotional level, the sexually addicted person experiences an inner conflict with his or her perception of the moral codes of society. This inner turmoil, combined with the continual pathological patterns of acting out, produces inconsistencies within their own core belief system. This contrast with "normal sexual behaviors" produce shame, low self-esteem and painful internal conflicts. In facilitating interventions in this area, it is extremely important for the clinician to understand the strong connection between shame and sexually compulsive behaviors. This dynamic also can be predominant in the members of the system around the patient.

The Dysfunctional System
There are many unique complexities associated with intervening the sexually compulsive patient and the associated "system." In facilitating this type of intervention, the therapist/interventionist will be most effective in using a systems-orientated framework for their clinical foundation. Although it may be inviting for the clinician to get hooked into the initial details reported, there will normally be many valuable answers and pieces to the puzzle beneath the original script. In other words, look beyond the obvious in formulating your intervention/treatment plan. Typically, you will find more than just one identified patient emerging from this dysfunctional system.

It may prove helpful to examine the reasons why spouses, sex partners, friends, etc., end up in relationships with the sexually addicted person. The participating person may be unaware of the reasons behind their selection process of friends, partners, etc. If the therapist can access the appropriate information, it will help everyone involved take the necessary steps to receive help. Examples of topics and concerns commonly encountered when preparing and executing the intervention are: rape, sexual abuse, sexual identification, drug and alcohol abuse, AIDS-HIV questions, physical abuse, children at risk, repressed memories, etc.

Pre-Intervention
Proper preparation for an intervention in which the primary diagnosis is sexual compulsivity/sexual addiction is critical. An initial telephone screening should be facilitated at the onset of the intervention process. The main objective of this screening or staffing is to establish the appropriateness and potential feasibility of moving forward to scheduling an intervention. This conversation normally takes place between the "point person" who initiated the first call and the therapist/interventionist.

This conversation provides the clinician with any information that may necessitate evaluation prior to assembling the "team members." There may be information that could be emotionally damaging to someone participating in the intervention. This information may still need to be accessed by the therapist/interventionist, but would not be appropriate to bring out in front of the team. It is never advisable to place anyone participating in the intervention at risk either emotionally or physically for the sake of attempting an intervention.

The Intervention
Because of the denial factor, secrets, shame and isolation, professional intervention may be one of the only options for successfully helping the sex addict get help. It is not uncommon for the sexually addicted patient to verbalize what a relief it is after the intervention has taken place stating, "I knew I was sick, and I couldn't stop, yet I did not know what to do or where to go for help. I felt so alone and hopeless." The intervention process presents a reality-based vehicle to break through this altered perception.

It is extremely important for the professional involved to remain dedicated to the original objective of the intervention. The specific intervention goal is to mirror the addicts' compulsive behavior back to them to break through their denial system. This is followed by the respectful facilitation of admission for treatment of the identified patient and family.

If the therapist/interventionist crosses the clinical boundary into areas of marriage therapy, psychotherapy or diagnosis, there is a great risk of forcing the process too fast without the benefit of having the appropriate clinical foundation in place to support the information. This may jeopardize or sabotage the possibility of future benefits normally gained from the therapeutic process of a well-timed contained disclosure and/or appropriate amends.

In determining the overall success of any intervention, it is recommended the therapist/interventionist guard against setting up team members to place all the importance on whether or not the individual identified patient enters treatment. The fact that everyone involved has had an opportunity to become educated, to put a voice to their feelings, and to begin setting boundaries to break through the denial in itself is a victory.

It is critical that the professional working with the intervention team includes information to help them understand that this is an illness and not lack of will power or a moral issue. Upon intervening the identified patient, he/she will most likely admit to having tremendous levels of shame, and there is no need to magnify the existing shame. It is my opinion that the healthiest choice anyone can make when learning about someone's sexual compulsivity is to begin the intervention process as soon as possible.

Intervention Screening Profile Questions

1. Identified patient profile. Discuss any past consequences, pending legal action, prior treatments, family and/or partner knowledge and involvement, outsiders knowledge, physical health issues, psychological profile, etc.

2. Confidential screening of potential intervention team members. Who are the appropriate people to engage in this sensitive process? How much do you disclose at this stage? It is the responsibility of the team leader to initiate all contacts once the screening is complete, and the potential team is mutually agreed upon. The therapist/interventionist may be open for legal repercussions if he/she contacts friends, colleagues, or family of the identified patient.

3. Geographic location and timing. When is the best time to plan the intervention? What about pre-existing plans; i.e. vacations, holidays or work commitments, etc.?

4. Discuss appropriate treatment provider options. Financial issues, insurance benefits etc. Are there any other untreated addictions, (i.e. chemicals), or potential depression, suicidal ideation or past history of suicide attempts?

5. Discuss private information and confidentiality. This gives the organizer the opportunity to discuss any details which may be inappropriate to bring out in the presence of the team.

6. Schedule the pre-intervention meeting and intervention.

Sexual Recovery Program
from the Sierra Tucson Treatment Center Inc.[2]

Philosophy of Treatment
Sierra Tucson's Sexual Recovery Program, as a component of the primary treatment program, provides additional treatment focus for patients addressing sexual issues. These issues include compulsive sexual and relational behavior, co-sexual addiction, sexual abuse, and incest, as well as family of origin issues related to sexual shame.

[2] The Sierra Tucson facility can be accessed on-line at www.sierratucson.com.

The Sexual Recovery Program operates with the philosophy that individuals have the right to recover as whole persons and, as such, deserve to address sexuality as a significant part of their recovery process. We are not in the business of proving or disproving memories of childhood abuse and we provide a safe environment in which individuals can explore their perceptions, their feelings, and the resulting effects they are experiencing.

Our treatment model has a strong focus on expressing feelings, reducing shame, understanding disease concepts and core issues of dependency, and using Twelve Step methods of recovery. The program emphasizes non-judgmental and non-blaming therapy designed to assist the individual in breaking through denial while experiencing unconditional acceptance and guidance.

Language of Treatment:

Sexuality
The sex act is only one part of sexuality.
Another important aspect of sexuality is one's biological gender and how one feels about being that gender (Sexual Identity). This includes also how one regards others of that gender and those of the opposite gender.

Whether one is sexual with the same sex, opposite sex or both, and the feelings one has about being sexual those ways (Sexual Orientation) is yet another part of one's sexuality. Physical maturity, physical health, hormonal and other body systems (Biological Functions) are also a part of our sexuality.

Intimacy
Sex does not equal intimacy. Sex may enhance existing intimacy but it does not create intimacy. Healthy adult emotional intimacy occurs when all persons in the relationship have equal power, risk emotional vulnerability and set boundaries to create an atmosphere of safety. Emotional intimacy takes time.

Sex Abuse
It's not just about sex...it's about power! It's when someone inflicts his or her sexuality on another. Overt abuse may involve physical touch. Covert abuse may not involve actual touching but can occur when pornography, sexual joking, shaming, comments, etc., are inflicted on another. Another subtle form of covert abuse is too much or a lack of sexual information during developmental childhood years.

Abuse is defined more by the effect on a person. The intent of the perpetrator often is not abuse, especially in more covert forms. The abusive effect is a result of the degree that a person perceives that he or she does not have unconditional choice in the matter. This often parallels the degree that the person feels like the victim.

Incest
Sexual abuse that occurs among known family members.

Sex and Love Addiction
As with any addiction, the purpose is to medicate feelings, to cope with life stresses. The sex and love addict finds himself/herself being compelled to be in a sexual relationship, often when not planning to be, in ways that were not planned and with people he/she did not plan to be

sexual. Often the addict wants or even tries to stop, but finds that he/she only changes to using other behaviors addictively or obsesses instead.

When not engaging in a sexual relationship, the sex and love addict is obsessing about a sexual relationship in some way. Other components of the addiction may be progression, physical, relational, financial, legal or employment consequences. Sex and love addiction is determined by compulsive patterns, not by isolated behaviors.

Sex Addiction
Is similar to sex and love addiction, but medicates with sexual behaviors other than a sexual relationship.

Co-Sexual Addiction
This is codependency in a sexual way: people-pleasing sexually, putting sexual partner's needs and values before, and many times to the detriment of one's own sexual needs and values. A core belief for the co-sex addict is that sex is love and love means sex.

PROGRAM OBJECTIVES
1. To provide general information on healthy sexuality.
2. To provide diagnostic assessments.
3. To provide therapeutic consults.
4. To provide education and information about disease concept of sexual/relational addictions.
5. To support actual applications of Twelve Step programs, i.e. written First Step, attendance at in-house Sex Addicts Anonymous and Survivors of Incest Anonymous meetings.
6. To provide therapeutic process to address sexual issues.
7. To provide therapeutically safe environment to allow patients to experience pain and shame reduction, and to process memories and perceptions.
8. To provide therapeutic tools to begin recovery together for identified couples.

Specific Treatment Interventions:
SRP Orientation is a one-time group for all patients. The purpose is to provide general information on healthy and unhealthy sexuality, and to provide familiarity with definitions of terms commonly used in the treatment process.

Individual appointments provide diagnostic assessment and/or therapeutic support to patients struggling with sexual issues.

Healthy Relationships Education is a one-hour workshop examining the meaning and qualities of intimacy throughout various stages of relationships. The workshop provides education regarding healthy relationships and practices tools through role-play.

Sexually Transmitted Disease Workshop is a one-hour workshop exploring symptoms, methods of transmission, diagnosis and treatment as currently known for STD's including an emphasis on HIV and AIDS. The workshop employs role-play about how to discuss safe sex with a partner, and demonstration and education on the use of condoms as an integral part of safe sex.

Sexual Abuse Group provides a psychodynamic process group for special attention to overt sexual abuse issues. Limited to six patients per group, this group meets two days per week just before Focused Expressive Group to allow maximum support and minimal interruption in the therapeutic process. After meeting on Monday and Tuesday morning, and having a few days to

process in Focused Expressive Group, the patients meet again on Thursday for some cognitive restructuring and boundaries planning around their specific dysfunctional re-enactments in adult relationships. Space permitting, this group can be attended more than one week during a patient's treatment.

Current Issues Group provides education to a specified population of patients regarding sexual addiction, co-sexual addiction, additive qualities and patterns of relationships and origins of these addictive qualities. Group exercises are utilized reduce shame associated with sexuality and establish healthy non-sexual bonds among patients in the group. This occurs in a three-week cycle that can be entered at any point in patients' treatments.

Each group contains two groups of education and group exercises, and a third group of cognitive restructuring through boundaries and relapse prevention. Topics addressed are symptoms of addiction/co-addiction, sexual shame, sex abuse, PTSD, family of origin dynamics, triggers to relapse, cycles of addiction and recovery.

Recovering Couples Group is limited to couples who want to work on a relationship and who have no secrets left between them. This is a one-time session with a Family Counselor to facilitate couples' open discussion of plans to maintain individual recovery while maintaining a relationship. Sexual Orientation Group is available weekly to patients wanting education and support in exploring their gay, lesbian, or bisexual orientation.

Sexual Addiction[3]
by Bernard G. Breining, Dr.AD

Sexual activity can be the highlight of a relationship; the culmination of a mutual sense of sharing and commitment that transcends reason, analysis, or thought.

It is perfect, in other words, unless and until is fails to fulfill the above criteria.

As many of the other behavioral addictions mentioned in this workbook, the activity takes second place to the risk, the excitement, the chance, the grandiosity, the possible loss of everything, the stimulation and anticipation of the action, rather than the somewhat normal, everyday accepted activity that poses no risk or excitement.

Recognition of this condition is vital to the intervention mentioned earlier, and acceptance of the condition as a "non-evil", somewhat normal human trait gone awry is a supposition, on the part of all concerned, that can lead to recovery.

Sexual fantasy is not evil, but rather quite normal and probably a healthy sign.

Sexual acting out, in an uninvited fashion, to fulfill a fantasy, is inappropriate and a sign of sexual dysfunction that calls for treatment, understanding, compassion and the opportunity to make changes and recover.

Name-calling and disrespect are counter-therapeutic.

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[3] From the ***Chemical Dependency and other Addictive Disorders – Workbook Three*** (1999), Breining Institute.

Compassion and understanding of the human condition, as imperfect as it is, is the first step in recovery for all concerned.

SUGGESTED ADDITIONAL READING

Hope and Recovery: A Twelve-Step Guide for Healing from Compulsive Sexual Behavior (1994), Hazelden.
P. Carnes, ***Out of the Shadows: Understanding Sexual Addiction*** (1983), Hazelden.
RH Earle and MR Earle, ***Sex Addiction: Case Studies and Management*** (1995), Brunner/Mazel, Inc.

ACKNOWLEDGEMENTS

The information contained within this Course Material has been drawn from many sources, including the references cited herein, the Breining Institute *"Chemical Dependency and other Addictive Disorders"* Workbook Series, the professional, academic and teaching experiences of Bernard G. Breining, Dr.AD, and research input from Breining Institute graduate students.

CONTINUING EDUCATION (CE) EXAMINATION QUESTIONS

Course No. CE1309 – Sexual Addiction

You are encouraged to refer to the Course Material when answering these questions. Choose the best answer based upon the information contained within the Course Material. Answers which are not consistent with the information provided within the Course Material will be marked incorrect. A score of 70% correct answers is required to receive Continuing Education credit. GOOD LUCK!

QUESTIONS

1. According to the article from NCSAC, relating to sexual addiction:
   a. 70% to 75% of addicts have thought about suicide.
   b. 40% of addicts experience severe marital and other relationship problems.
   c. Both A and B.
   d. Neither A nor B.

2. What percentage of sex addicts have had a concurrent addiction such as alcoholism, eating disorders or compulsive gambling:
   a. 26%
   b. 52%
   c. 83%
   d. 91%

3. According to Dr. Fearing:
   a. Sexual addictive behavior is unique and shares no similarities with more commonly treated addictions.
   b. There is a predominant experience of overwhelming shame among sexually addicted individuals.
   c. Both A and B.
   d. Neither A nor B.

4. Examples of concerns commonly encountered during an intervention include all but which of the following:
   a. Sexual abuse.
   b. Drug and alcohol abuse.
   c. Physical abuse.
   d. Financial abuse.

5. According to Dr. Fearing, the intervention participants should recognize that:
   a. Sexual addiction demonstrates a lack of will power that can be cured.
   b. By magnifying the shame involved with sexual addiction, this will assist in a quicker return to acceptable behavior.
   c. The therapist should cross the clinical boundary into areas of marriage, psychotherapy or diagnosis, in order to more quickly identify where the addictive behavior originated.
   d. It is likely that the client/patient will admit to tremendous levels of shame.

6. The Intervention Screening Profile should consider which of the following:
   a. Confidential screening of potential intervention team members.
   b. Appropriate treatment provider options.
   c. Geographic location and timing of the intervention.
   d. All of the above.

7. According to the Sierra Tucson Recovery Program:
   a. The sex act is the primary part of sexuality that should be examined.
   b. A person's biological gender and how one feels about being that gender are not import aspects of sexuality.
   c. Physical maturity and physical health are part of our sexuality.
   d. None of the above.

8. Covert sexual abuse:
   a. Necessarily involves touching.
   b. Can occur when pornography or sexual joking are inflicted on another.
   c. Both A and B.
   d. Neither A nor B.

9. Co-sexual addiction:
   a. Is co-dependency in a sexual way.
   b. Involves putting sexual partner's needs and values first.
   c. Involves the belief that "sex is love" and "love means sex."
   d. All of the above.

10. According to Dr. Breining:
   a. Sexual fantasy is an abnormal behavior that should be modified or eliminated.
   b. Sexual "acting out" in an uninvited fashion, in order to fulfill a fantasy, may be an acceptable treatment modality.
   c. Showing disrespect immediately to a sex addict demonstrates that they are engaged in unacceptable behavior, which is the first step toward recovery.
   d. None of the above.

This is a ten-question examination. Answer Questions 1 through 10 for full CE credit in this course. Questions 11 through 21 have been omitted.

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CONTINUING EDUCATION (CE) ANSWER SHEET

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Course Title: **CE-1309 / SEXUAL ADDICTION**
Answers (circle correct answer):

1.	A	B	C	D	8.	A	B	C	D	15.	A	B	C	D
2.	A	B	C	D	9.	A	B	C	D	16.	A	B	C	D
3.	A	B	C	D	10.	A	B	C	D	17.	A	B	C	D
4.	A	B	C	D	11.	A	B	C	D	18.	A	B	C	D
5.	A	B	C	D	12.	A	B	C	D	19.	A	B	C	D
6.	A	B	C	D	13.	A	B	C	D	20.	A	B	C	D
7.	A	B	C	D	14.	A	B	C	D	21.	A	B	C	D

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