Sexual Addiction

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- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a behavioral health professional or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
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Faculty

Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT, (she/they) travels internationally speaking on topics related to EMDR therapy, trauma, addiction, expressive arts, and mindfulness while maintaining a private practice and online education operation, the Institute for Creative Mindfulness, in her home base of northeast Ohio. She is the developer of the Dancing Mindfulness approach to expressive arts therapy and the developer of Yoga for Clinicians. Dr. Marich is the author of numerous books, including EMDR Made Simple, Trauma Made Simple, and EMDR Therapy and Mindfulness for Trauma Focused Care (written in collaboration with Dr. Stephen Dansiger). She is also the author of Process Not Perfection: Expressive Arts Solutions for Trauma Recovery. In 2020, a revised and expanded edition of Trauma and the 12 Steps was released. In 2022 and 2023, Dr. Marich published two additional books: *The Healing Power of Jiu-Jitsu: A Guide to Transforming Trauma and Facilitating Recovery* and *Dissociation Made Simple*. Dr. Marich is a woman living with a dissociative disorder, and this forms the basis of her award-winning passion for advocacy in the mental health field.

Faculty Disclosure

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for professional clinicians such as counselors, social workers, pastoral counselors, and nurses who would benefit from additional competence on how to assess for sexual addiction and how to make the best referral for care.

Accreditations & Approvals

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NetCE designates this continuing education activity for 6 hours for Alabama nurses.

AACN Synergy CERP Category A.

Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

NetCE designates this continuing education activity for 2.5 NBCC clock hours.

NetCE designates this continuing education activity for 5 continuing education hours for addiction professionals.

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Course Objective

The purpose of this course is to provide healthcare professionals the information necessary to conduct a thorough sexual history and allow a clear and nonjudgmental approach to issues surrounding sexuality and sex addiction.

Learning Objectives

Upon completion of this course, you should be able to:

1. Compare the concepts of sexual compulsivity, sexual addiction, and sexual anorexia with identified norms for healthy sexuality.
2. Articulate some of the controversies that exist about the concept of sexual addiction.
3. Assess for sexual compulsivity, sexual addiction, and sexual anorexia in a presenting client.
4. Implement basic strategies for addressing sexual compulsivity, sexual addiction, and sexual anorexia as part of a comprehensive treatment program.
5. Identify personal barriers in clinicians that may exist to assessing or treating sexual addiction.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

In many global cultures, nothing captures attention quite like sex. Sex is used in advertising at an ever-increasing rate to sell everything from candy to socks. The sexual content in movies, music, and television continues to make an impact with modern audiences, whereas the same content would have scandalized previous generations.

In a popular sense, sex fascinates and intrigues, but in a clinical sense, there is still a significant stigma connected to sex. Clients are often embarrassed or ashamed to discuss sex; however, perhaps more alarming is how clinicians are just as likely to steer clear of the "s" word. The sexual history portion of clinical assessments is often only addressed surfacely. This is compounded by the fact that clinicians feel underprepared to conduct a thorough sexual history or to assess for conditions like sexual addiction.

It is estimated that between 3% and 6% of Americans struggle with sexual addiction [82]. A major reason for the wide range in this estimate is the stigma associated with reporting addiction or otherwise embarrassing sexual conditions. Despite this stigma, the estimated prevalence of sexual addiction in the United States is greater than the rate of eating disorders and gambling addiction disorders combined [1]. Although sexual addiction is clearly a significant public health issue, graduate programs in counseling and other human services often have no requirement for education regarding human sexuality. This contributes to environments in which clinicians feel too embarrassed or inexperienced to address the issue with their clients [2].

A clinician who conducts a thorough clinical assessment of an individual, including issues related to sexuality, obtains enhanced insight because sexuality is a vital aspect of the human experience. By including sexuality as a facet of the holistic approach to mental health care, clinicians enhance the efficacy of treatments and clients' quality of life.

Despite this information, clinicians continue to debate whether or not sexual addiction can be classified and treated in the same realm as chemical addictions. This course will provide mental health professionals with information on several core concepts: sexual compulsivity, sexual addiction, sexual anorexia, aspects of healthy sexuality, assessing sexual addiction, and treating sexual addiction. Other topics covered include controversies about sexual addiction, family aspects of sexual addiction, modern sexual commerce, and personal/professional barriers in addressing sexual addiction.

In the past several years, sex addiction seems to have become a more controversial rather than a less controversial topic. Many people in professional circles argue that even labeling sex as addictive goes against sex-positivity efforts, especially in LGBTQ+ spaces. As will be discussed in this course, two things can be true at the same time--one can be sex positive while also helping a person decide whether or not their sexual behaviors are bringing more or less peace to their lives. The idea of sex addition is simply a guiding construct. The key to trauma-informed care is to help a person embrace language that works for them. So, in the spirit of an open mind, if the phrase "sex addiction" does not work for you and your clients, explore whether another phrase works better to describe the phenomena discussed in this course.

HEALTHY SEXUALITY

A complete appreciation of sexual addiction requires an understanding of healthy sexuality. As clinical assessors, mental health professionals require a standard by which to compare problematic sexual presentations. In addition, when treating a client with sexual addiction, one of the first tasks is to provide the individual with basic psychoeducation regarding healthy sexuality.

Carnes has identified eight dimensions of healthy sexuality [21]:

- Nurturing: The ability to care for self and to accept caring from others
- Sensuality: An awareness of senses (e.g., temperature, texture, color, sound, taste, and smell)
- Sense of self: The capacity to know and express desires, wants, and areas of discomfort
- Relationship sexuality: The ability to sustain warm and caring friendships that are not erotic with both the same and opposite sex
- Partner sexuality: A special intimacy with a partner that is clearly erotic
- Nongenital sexuality: The exploration of all the ways to be sexual without involving genital contact
- Genital sexuality: The ability to abandon self to passion in a temporary surrender of ego and control via genital stimulation
- Spiritual sexuality: An extension of the search for meaning and spirituality in a partnership

In many cases, individuals will circumvent earlier stages of sexuality (e.g., nurturing, sense of self) and immediately begin their sexual experiences at a more advanced stage (e.g., genital sexuality) [21]. Having little or no appreciation for the earlier stages of healthy sexual development is relatively common today, but earlier stages are essential to developing healthy sexuality. One of the main early goals in treating a sex addict (or any addict) is to help the client recover a lost sense of self or establish a sense of self that never existed in the first place.

There are other important ideas about healthy sexuality that may be useful for recovering clients. In sexually addictive scenarios, men tend to objectify their partners or use sex as a means of power, whereas women use sex as a substitute for intimacy and affirmation [9]. For a couple, healthy sexuality will include mutual respect and using sexuality to express intimacy, affirmation, love, and caring. Sex is an element of a loving relationship and a celebration of life that should be an enriching, not a degrading experience [1]. Sexuality that is a part of the holistic self prevents sexually acting-out behaviors [26].

Safe environments that support non-judgmental attitudes are ideal for the development of healthy sexuality [6]. This safety is critical to recovery from addiction, and it is often challenging to establish, especially when the addict is dealing with a hurt and therefore critical partner. If the partner is alienating the recovering addict initially, the use of a group support system becomes even more vital. Connection with a healthy community or support network offers connectedness with others in general; this quality is identified as a component of healthy sexuality [26].

Many 12-step recovery programs are described as spiritual (though not religious) programs. In the heritage of 12-step programs, spirituality has often been viewed as the only element potent enough to solve the complexities of addiction. Many clients (and therapists) do not wish to involve spirituality in addressing presenting problems. However, if a client is open to spiritual solutions, developing spirituality can have a positive impact on sexuality. According to Laaser, fulfilling sexuality is often concomitant with spiritual clarity [26]. Carnes noted that healthy, successful sex and a well-developed spirituality are inextricably linked, and Nelson indicated that the "common component of spirituality and sex is the search for meaning" [6; 21]. According to Maslow, self-actualizing individuals often experience orgasm as a spiritual, mystical event [6]. If one has a clear understanding of self and is at peace, the capacity for sexual expression can be greatly enriched.

FOUNDATIONS AND DEFINITIONS

Several terms are used to describe various types of disorders of sexuality, including:

- Sexual compulsivity
- Sexual impulsivity
- Sexual addiction
- Sexual anorexia

Each of these terms may elicit different responses. In reality, each refers to a unique clinical entity, but there is overlap as well. A clear understanding of these concepts is necessary for all clinicians involved in the care of clients with disordered sexual practices or compulsions.

COMPULSIVITY AND IMPULSIVITY

The terms compulsivity and impulsivity are often used interchangeably in clinical settings. However, this is incorrect. The American Psychological Association defines these concepts as [3]:

- Compulsive behavior: A behavior or a mental act engaged in to reduce anxiety or stress
- Impulsive behavior: A behavior that displays little to no forethought, reflection, or consideration of consequences

Compulsive behaviors are generally more patterned and have a clear purpose: to alleviate anxiety. The classic obsessive-compulsive behavior of excessive handwashing, for example, is engaged in to relieve disturbing mental obsessions about germs, dirtiness, or other sources of anxiety. On the other hand, impulsive behavior is usually not planned, consciously or unconsciously. When it comes to sex, many individuals participate in sexually impulsive acts. Engaging in such acts does not necessarily make one a sexual compulsive or a sex addict, just like getting drunk one time does not make a person an alcoholic. However, if the impulsivity develops into a pattern, an individual may be experiencing a form of sexual addiction.

According to some sexual addiction experts, compulsivity, as it applies to any addiction, refers to the behavior (e.g., sexual activity, drinking, gambling) being out of control [4]. Not all instances of sexual compulsivity are necessarily part of a broader sexual addiction condition; some instances of sexual compulsivity or impulsivity are tied to a more clinically significant Axis I or Axis II disorder [1]. For example, sexual compulsivity could be a feature of manic episodes, a facet of a borderline personality disorder, or better explained by a paraphilia diagnosis as delineated by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) [5]. This is not to say that a person with bipolar disorder, for instance, cannot be a sex addict, but careful assessment is necessary.

Interestingly, many clinicians and professionals prefer the term sexual compulsivity to sexual addiction, typically because they are not comfortable with the concept of addiction [6]. However, as with compulsivity and impulsivity, there is a difference, and this difference should be clearly understood.

SEXUAL ADDICTION

While the DSM-5-TR does include a category of Substance-Related Disorders, it generally does not use the term addiction in its descriptions of individual disorders. The DSM-5-TR uses the label substance use disorder to identify chemical addiction [5]. Gambling addiction is referred to simply as gambling disorder, and other conditions that are often referred to as addiction could be labeled as impulse control disorders. However, addiction is used widely as an all-inclusive clinical term, and the term appears in the names of many professional associations, such as the American Society of Addiction Medicine, the National Association for Addiction Professionals, and the National Institute on Drug Addiction. For the purposes of this course, the term "addiction" will be used to describe continuing a behavior (e.g., drinking alcohol, smoking cigarettes, gambling, engaging in sexual activity) even when the activity causes repeated pain and consequences [7].

Addiction usually implies a holistic impact on an individual as a result of continuing to engage in the harmful behavior. Carnes defines sexual addiction as an entire pattern of maladaptive behaviors, cognitions, belief systems, and consequences; the behavior alone can be identified as sexual compulsivity [1]. A simple way to identify addiction compared to compulsivity is to recognize that addiction involves how compulsive behaviors impact (or are impacted by) the rest of a person's functioning.

In the treatment field at large, use of the term addiction is becoming increasingly unpopular and, in some sectors, discouraged [90; 91]. While this course makes an argument for continued use of the concept of addiction, whatever descriptors that work best for clients should be considered, in the spirit of client-focused care.

Various experts in sexual addiction have attempted to define the disorder. Laaser views sexual addiction as a situation in which a behavior that is generally healthy (i.e., sex) becomes unhealthy [26]. Carnes, on the other hand, identifies sexual addiction as "a pathological relationship with a mood-altering experience" [83]. Weiss identifies a sex addict as someone who, like an alcoholic or overeater, uses sexual compulsions "to avoid past or present pain and escape the realities of life" [8]. Nelson characterizes sexual addiction as usage of sex as a mood-altering substance that continues to be used in greater dosages, eventually permeating every aspect of an individual's life [6]. Crowe and Earle identify sex addicts as people who are afraid of intimacy and repeatedly and compulsively try to connect with others in highly impersonal ways (e.g., prostitution, masturbation, cybersex, emotionless affairs) [6]. This point about the fear of intimacy and lack of genuine connection is a key aspect of sexual addiction and will be explored in more detail later in this course.

The Sex Addiction Cycle

There are many models for understanding addiction. In his influential work on sexual addiction, Carnes identified four stages of the sexual addiction cycle (although this cycle can apply to chemical and other behavioral addictions as well) [10]:

- Preoccupation
- Ritualization
- The sexual act
- Despair/depression

According to this model, preoccupation is commensurate to the mental obsession. That obsession could be about using a drug or alcohol, past resentments or abuse, or simply the ruminations of a bad day. The only thing that will bring relief to the mental noise of the obsession is to begin the chase toward feeling good, defined in stage 2 as ritualization. Ritualization may be defined as the routine or the "chase" that a person engages in to obtain their addictive substance or behavior. This could be driving to a certain bar or getting ready for a night out. Many addicts describe the ritualization prior to obtaining the substance or engaging the behavior as more of a rush than engaging in the behaviors themselves.

Following the ritualization is the act itself, in this case, a sexual behavior. One of the diagnostic criteria for substance use disorder is the development of tolerance, or the increased need over time to achieve the same effect as was achievable with less stimulation at an earlier point [5]. This phenomenon applies for many sex addicts.

Feelings of shame, guilt, remorse, or physical discomfort usually result after the effects of the behavior dissipate. This is the essence of stage 4, despair/depression. People in active addiction often do not have the functional coping skills to deal with these emotional states, and using the substance or engaging in the problematic behavior is perceived as the most logical way to alleviate the depression or resolve the despair. And thus, the cycle begins again.

Types of Sexual Addictive Disorders

Carnes has identified ten major classifications of sexually addictive disorders [9]:

- Fantasy sex: Obsessive thoughts about a sexual fantasy rather than actual sexual behavior
- Seductive role sex: Persuading or manipulating another (a "conquest") to engage in sexual contact
- Anonymous sex: Sex with a stranger, often characterized by multiple "one-night stands"
- Paying for sex: Financially compensating a sex partner (e.g., paying for prostitutes) or paying for sexual arousal (e.g., explicit phone calls), essentially as a business arrangement
- Trading sex: Receiving compensation in return for sexual acts
- Voyeuristic sex: Observing others engaged in a sexual act (including pornography), often combined with excessive masturbation
- Exhibitionist sex: Exposing oneself for the purpose of sexual pleasure (e.g., flashing, posing for pornographic pictures or films)
- Intrusive sex: Sexual contact with an individual without his or her consent
- Pain exchange: Giving or receiving pain for the purpose of pleasure (i.e., sadomasochism)
- Exploitive sex: Forcing an individual to engage in sexual contact against his or her will or with a victim unable to consent (e.g., a child)

As this list of classifications progresses, the activities are progressively more intrusive on the other party and are less likely to involve a meaningful connection. The likelihood of legal consequences as a result of this intrusion increases as the list progresses as well. It is essential to note that all ten categories demonstrate an essential absence of intimacy with the partner involved. There are some exceptions; for example, a loving couple may engage in seductive role sex as part of a healthy sexual relationship. However, the further the category is down on the list, the less the chance of these exceptions.

In looking at this list, consider the role of the classic concept of tolerance in addiction and how it may affect a sex addict's behaviors. An individual may stay within one classification of sexually addictive disordered behavior and simply engage in more and more of that activity. Or, a sex addict may escalate from less intrusive behaviors to more intrusive or risky activities in order to attain the "rush" he or she is seeking.

SEXUAL ANOREXIA

Sexual anorexia, also referred to as hyposexual desire disorder, is not a widely known or appreciated concept. In work with any sexual addict, deprivation of sexual expression should not necessarily be the treatment goal [64]. Yet, sexual deprivation is how many sexual addicts choose to deal with their addiction. It may be equated to the "cold turkey" approach of drinking or smoking cessation.

In the DSM-5-TR, there are two sexual desire disorders: female sexual interest/arousal disorder and male hypoactive sexual desire disorder [5; 84]. Both disorders may be marked by absent/reduced interest in sexual activity, sexual/erotic thoughts or fantasies, and/or initiation of sexual activity, though the female condition may also include physiologic nonresponse to sexual cues. The term sexual anorexia encompasses both of these disorders.

The word anorexia is generally defined as being without appetite. Nelson has described sexual anorexia as an obsessive state in which the physical, mental, and emotional task of avoiding sex dominates one's life [6]. Sexual addiction and sexual anorexia can exist in the same person or same family at one time; extremes are the common theme. Often, a cycle of binging on sexual compulsions then abstaining entirely becomes apparent. Both conditions (addiction and anorexia) consist of an obsession with sex, but the object or manifestation of the obsession is different. In many cases, this anorexic behavior is a response to recognized addictive behavior or trauma [11].

The idea of sexual anorexia and the addiction/anorexia cycle may be difficult to understand. However, clients who present for clinical attention are often plagued by all-or-nothing thinking—in this case, engaging in as much sexual activity as possible or none at all. Sexual anorexia is quite parallel to "dry drunk syndrome" seen in some chemical addicts [65]. Simply put, these individuals are abstinent but have not addressed any of the emotional issues that motivate their problem drinking or drug use (e.g., no recovery). "Dry drunks" are often impatient, depressed, irritable, impulsive, and difficult to be around as a result of the removal of their coping mechanism (e.g., drinking) without replacement with healthier coping strategies. Sexual anorexia is similar. If the core motivating issues are not addressed, a sex addict may evolve into a sexual anorectic who is depressed and difficult to be around. As such, sexual anorexia can lead to its own level of interpersonal problems. Furthermore, those who stop any addictive behavior but do not address the underlying issue(s) are at greater risk of relapse.

Sexual anorexia has also been linked to rigid (to the point of compulsive) religiousness [11]. Sexual anorexia can result when individuals use religiosity to address their sexual addiction; this is often prefaced by a period of religious compulsivity [12]. Unfortunately, sexual anorexic behaviors may be encouraged as a "cure" for sexual addiction by some therapists or counselors, particularly if a client is seeking help from within their faith community.

CONTROVERSIES IN THE LITERATURE

Although sexual addiction is more widely accepted today, controversies regarding its definition and diagnostic criteria still exist [13]. This section will examine some of the criticisms regarding the existence of sexual addiction and compulsivity.

MORAL MODEL

Prior to the advent of Alcoholics Anonymous in 1935 and the American Medical Association's recognition of alcoholism as a disease in 1952, alcoholism and addiction were largely viewed as sin problems [14]. This perspective is referred to as the moral model. According to this view, alcoholics and addicts are morally flawed, and repentance, conversion, or total commitment to a religious program will address the sin and solve the problem. Interestingly, this moral model view still abounds in many circles today.

In addiction treatment, the moral model views addicts as weak-willed and essentially faulty. Many religious groups, specifically those with more fundamentalist or conservative beliefs, approach addiction as a sin problem, not a treatable disease. Compulsive behaviors are best addressed through dedication to the spiritual pursuits as defined by the tenets of that religion. Examples of such cure-through-religion courses or counseling include Blazing Grace and Reformers Unanimous International Ministries, which address addiction problems primarily through the use of biblical passages, and Comunità Cenacolo, a conservative Catholic movement that rejects the idea of therapeutic intervention and advocates addicts living together as a religious community to overcome addiction problems [15; 16; 17]. These three programs are a few of the many faith-based programs that still operate from the moral model. In most cases, these extreme faith-based programs reject, and often condemn, the necessity of therapeutic intervention. However, it is important to note that not all faith-based recovery programs are as extreme in their moral model stance as the programs listed here.

DENIAL OF SEXUAL ADDICTION

On the other end of the spectrum from the moral model is the notion that sexual addiction does not exist at all. Some professionals argue that sex addiction is a pseudoscientific cover-up to promote puritanical moral values by the mainstream establishment. One such critic contends that "sex addiction has also been used as a political justification for censorship, eliminating sex education and birth control clinics, and opposing equal rights for gays and lesbians" [18]. Others in the general public believe sex addicts just enjoy sex; the addiction label is only used when they face consequences of their sexual behaviors. Indeed, using addiction as an excuse for poor behavior is not a new concept.

OTHER CRITICISMS

Several theorists suggest that ingestion or reliance on a physical substance is needed to truly justify addiction or dependence. These theorists argue that forms of sexual activities are interactions, not substances [1]. In response, Weiss notes that "acting out sexually becomes the primary way to meet the chemical needs of the brain" [9]. Indeed, anyone who takes an introductory course in addiction learns that it is the dopaminergic response in the brain that makes an experience addicting. Sexual arousal can trigger the release of dopamine and other hormones, including endorphins, which are neurotransmitters in the brain with properties similar to morphine. Some studies have indicated that viewing sexually explicit images can induce the same dopamine response as heroin in addicts [19]. However, a study published in 2013 found that neural responsivity to visual sexual stimuli did not significantly differ in persons with hypersexuality issues compared to healthy controls [85]. Some argue that this lack of verifiable biologic response (as seen in persons with substance dependence) is evidence that sexual addiction is not a real clinical entity.

RESPONSE TO CRITICISMS

From a psychosocial perspective, sexual addiction, according to Nelson, qualifies as an addiction based on a client's overwhelming preoccupation with sex, disregard for consequences, and inability to stop on his/her own; these qualifications are similar to the DSM-5-TR criteria for substance use disorder [5; 6]. In the DSM-5-TR description of substance use disorder, physical dependence and withdrawal (two obvious physical criteria) are not required. A diagnosis may be assigned based solely on the psychosocial aspects (e.g., persistent but unsuccessful efforts to quit, time spent in pursuit of the substance, important activities given up, etc.) if the consequences experienced by the client are pervasive enough to impact total life functioning. Lemon has suggested that three characteristics of substance use or behaviors may lead to addiction: "relatively rapid and substantial improvement in hedonic state, user unable to find alternative ways of obtaining this improvement, and performance of the behavior leads to maladaptive functioning and chronic dysphoria" [20]. Using these criteria as a guide, any behavior or substance may qualify as an addiction.

Second, there is controversy about sex addiction because there is a great amount of disagreement in the literature regarding what constitutes addiction, relapse, or recovery. Once again, disagreement among professionals and those who write about addictive disorders can often lead to a lack of standardization in how treatment is conceptualized and delivered [66].

ETIOLOGY OF SEXUAL ADDICTION

In his early writings on the topic, Carnes identified shame and abandonment as the core etiology of sexual addiction [21]. As the area of sexual addiction research and treatment has evolved, the belief that shame underlies sexual addiction has been reiterated [6].

Shame is defined by the American Psychological Association as "a highly unpleasant self-conscious emotion arising from the sense of there being something dishonorable, ridiculous, immodest, or indecorous in one's conduct or circumstances" [3]. There is a popular saying that guilt is feeling bad about what you have done, while shame is feeling bad about who you are. Thus, if shame is an underlying core of sexual addiction, many clients with these problems have pervasive, untreated emotional wounds from past experiences that have inhibited the fostering and establishment of genuine intimacy with others.

It has been estimated that between 35% and 80% of sex addicts were sexually abused as children [10; 22; 23]. Earl and Earl contend that sexual abuse leaves a legacy of low self-esteem, secretiveness, abandonment fears, superficiality, blurred boundaries, distrust, mood disorders, escape strategies, dehumanizing sexual attitudes, undeveloped social skills, isolation, and loneliness [25]. These effects of sexual abuse are also characteristics of the ten categories of sexual addiction discussed previously and can result in negative thoughts and self image. According to Carnes, four beliefs are common among sex addicts [10]:

- I am basically a bad, unworthy person.
- No one would love me as I am.
- My needs are never going to be met if I have to depend on others.
- Sex is my most important need.

These common beliefs often must be addressed when treating a sex addict, especially when using a traditional cognitive-behavioral model [10].

Of course, not all sex addicts are victims of childhood sexual abuse (and vice versa), and generalizing that sexual addiction struggles are always linked to sexual abuse is a disservice to clients. According to Laaser, people from rigidly religious homes who were raised with negative messages about sex are more likely to develop sexual addiction [26]. Again, the common link is the presence of shame-based attitudes toward sex. Shame can quickly become overwhelming, and an individual's brain may seek chemical relief from the intense state of shame.

A few other etiologic points must also be considered. Pornography, particularly when viewing is initiated earlier in life, has been identified by some as a doorway into sexual addiction, although this has been an issue of debate [24; 27; 86]. It is true that as accessibility to pornography (via the Internet) has increased, the prevalence of sex addiction has also increased. However, a causal relationship has not been clearly established.

Others identify sexually acting out behaviors as a potential effect of unresolved grief over previous relationships [28]. Experts have indicated that masked grief reactions can lead to maladaptive behaviors, including compulsive acting out or addictive behaviors [29].

High comorbidity also exists between sexual addiction and mental health disorders, most notably depression, anxiety, and substance abuse. Common themes among these clients tend to be feelings of hopelessness, helplessness, despair, and shame [1]. For these individuals, sex behaviors may be an attempt to "feel good," however briefly, and relieve anxiety [9].

THE INTERNET AND MODERN COMMERCE

The increased incidence of sexual addiction may be linked to the accessibility and affordability of online materials [1]. As discussed, this is a controversial subject. Some professionals see a clear connection between accessibility and development of addiction, whereas others feel that addicts will find the materials regardless of whether they are easily accessible or not. The increase in accessibility to sexual material in recent decades cannot be denied, and it is not just limited to pornography. Advertising has become increasingly sexual, as have popular music, movies, and television. The sexual imagery in popular culture today would have been unthinkable years ago.

Exposure to these images via the media can activate the pleasure centers of the brain; if the synapsal firing in the pleasure centers is excessive, particularly in youth, a faulty wiring system can set in. However, research in this area remains scarce.

Exposure to pornography (including unwanted exposure) among children and adolescents in the United States has increased with the widespread use of the Internet [67; 68; 69]. Additionally, a 2010 survey found that 9% of Internet users 10 to 17 years of age had been victims of unwanted sexual solicitations (e.g., being asked to talk about sex or for personal sexual information), but this represented a 30% decrease from the rate reported in 2005 [30]. This decline in unwanted sexual advances was mainly among pre-teens (10 to 12 years of age) [31]. However, the researchers noted that more solicitations were made by friends and acquaintances, and less by strangers, and most solicitations occurred over social media [31]. The most significant numbers of unwanted sexual solicitations were to male gay-identified and female adolescents [81].

A meta-analysis including 40 studies from 1990 to 2016 reported that the rate of unwanted online sexual exposure for youth between 12 and 16.5 years of age was 20.3% [88]. The prevalence for unwanted sexual solicitation was 11.5% [88]. Another study found that psychiatric disorders were significantly higher in adolescents who were exposed to sexual solicitation online. For example, the prevalence of post-traumatic stress disorder after exposure to unwanted sexual solicitation was 57.8% [89].

While research does seem to indicate a correlation between excessive or problematic Internet use for sexual purposes and negative effects, causation has not been clearly determined [79; 80]. Some have proposed that a different type of sexual addiction, stemming more from early exposure to graphic sexual material via the Internet than previous trauma, could be developing, with a more rapid onset and differences in chronicity and content [87]. Maltz advises a prevention model, especially in the wake of the problems of Internet pornography and the realities of modern commerce [32]. She urges that cases of pornography-related problems should be addressed on a case-by-case basis to determine the best treatment approach. This requires a comprehensive and extensive evaluative process.

IMPACT OF SEXUAL ADDICTION ON THE FAMILY

Because of the relational element inherent in sexual compulsivity and sexual addiction, the impact on the family is often profound. Many of the same co-dependency or co-addiction elements that professionals see in treating partners of chemical addicts manifest in the partners of sex addicts. Codependency refers to a relationship in which one partner is psychologically attached in an unhealthy way to an addicted partner and/or that partner's addictions. However, addressing the hurt of a sex addict's partner is often (not always) more complicated for many reasons, including, but not limited to, shame, embarrassment, jealousy, inadequacy, taking the addiction personally, and feeling sexually insufficient. Studies continue to show that most sexual compulsives are in a relationship [33]. This suggests that sex addicts desire the security of a monogamous relationship but are unable (or unwilling) to experience the intimacy required to sustain such a relationship.

Partners of sex addicts often express the feeling that they are "permanently damaged" or "not good enough." Considering that many partners personalize the sexual addiction, these cognitions are not surprising. When the partners have acquired these, or similar, messages of insufficiency or worthlessness in childhood or adolescence from their families of origin, the sexual acting out of the addicted partner can exacerbate existing mental health issues.

Many of the same techniques used to treat core issues of shame and negative cognition in sexual addicts can also be used to treat the partner and family [73]. The techniques used in the treatment of partners and children of chemical addicts can also be applied to family members/partners of sex addicts. Moreover, 12-step groups like Al-Anon and Adult Children of Alcoholics (ACOA) have counterparts such as the S-Anon fellowship. If such groups are not readily available, partners of sex addicts may attend Al-Anon, ACOA (especially if there is also an issue with chemical addiction), or Codependents Anonymous (CODA). Many of the themes discussed at these meetings translate well to treating codependency or co-addicted sex addicts.

One can also not underestimate the impact that sexual addiction has on children of sex addicts [70; 71; 72]. According to a survey of adult children of sex addicts, parental sexual addiction affected the children in many different arenas, specifically in the development of healthy ideas about self-esteem (81%), morality (67%), spirituality (79%), finances (45%), emotional stability (70%), social interactions (71%), dating (71%), and marriage (69%) [8]. Another survey found that children of sex addicts had increased incidences of sexual addiction (64%), depression (62%), eating disorders (38%), and sexual anorexia (17%) [8].

ISSUES IN THE ASSESSMENT OF SEX ADDICTION

GENERAL PRINCIPLES

High comorbidity exists between substance use disorders and sexual addiction. Hagedorn and Juhnke contend that those trained to treat chemical dependency should also be trained to treat the commonly comorbid sexual addiction [1]. Part of meeting this challenge is recognizing the reality of process addictions. Process addictions are often referred to as behavioral addictions and include such addictions as sex, gambling, shopping, Internet use, sports, and eating. The term suggests that the behavioral act, or process, is the most addictive aspect, not necessarily the result of engaging in that activity. O'Brien has suggested that a good starting point for conducting assessments is the exploration of out-of-control behaviors and their consequences, even more so than physical tolerance and withdrawal [1]. O'Brien's contention stems from the idea that any substance and any behavior can become addictive as long as it has the potential to create debilitating behavioral consequences.

Underlying sexual addiction issues may be a driving force behind the more readily identifiable chemical dependency issues [1]. According to Seegers, among those who have experienced co-addictions, most have identified sexual addiction as the most difficult recovery [9]. A comprehensive sexual history should be gathered in order to distinguish between sexual addiction, the compulsion aspect of obsessive-compulsive disorder, an impulse control disorder, or a paraphilia [1]. According to the DSM-5-TR, paraphilia is an umbrella term for mental illness characterized by "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (e.g., exhibitionism, frotteurism, voyeurism, pedophilia, sadism, masochism) [5].

Clinicians experienced in conducting thorough biopsychosocial-spiritual assessments should not find assessing for sexual addiction difficult provided they are willing to talk to clients about sexual development and activity. The impact of a client's sexual behavior should be examined in the scope of the entire biopsychosocial presentation in order to intelligently assess if the behavior is part of an addictive spectrum or if it can better be explained by another mental health issue. In some cases, there will be no pathologic behavior. Both Maltz and Kort, who have divergent views of pornography use, caution that not all instances of pornography use or sexually acting out are necessarily sexual addiction [34; 35]. Context is key—the effect of sex (or lack of sex) on the individual's life is important. This will ultimately guide the creation of a treatment plan.

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the British Association for Sexual Health and HIV, sexual history taking should take place in a confidential, private environment.

(https://www.bashhguidelines.org/media/1241/sh-guidelines-2019-ijsa.pdf. Last accessed March 29, 2023.)

Strength of Recommendation/Level of Evidence: ID (Strong recommendation based on non-analytic evidence)

Cultural sensitivity and respecting a client's individuality are critical in conducting the sexual history. Certain cultural or societal pressures or special issues may be inherent to the development of his or her addiction. For example, shame can play a significant role in the developmental histories of gay and lesbian youth or in individuals raised in rigidly religious homes. With such individuals, it may be impossible to gain all of the necessary information in a first assessment session, or until the client feels safe. Assessment should be considered an ongoing process.

Knowledge about human development can assist with the assessment process. Often, adult clients will conduct themselves sexually as adolescents. This conduct should be explored to determine its meaning in terms assessment and/or treatment. Keeping development in mind is also important in evaluating context. Adolescent hormonal changes (often seen as a standard developmental marker) can explain normal increases in sexual interest and activity, though clients may feel their interest is "excessive."

Be aware of the hidden nature of sexual addiction. Intense stigma often leads to significant minimization and rationalization by both the client and their families. This trend really can apply to any addiction, but it seems to be most pervasive with sexual addiction and sexual co-addiction. Hagedorn and Juhnke recommend involving the family in the screening and assessment process to obtain collateral data when appropriate [1].

SCREENING INSTRUMENTS

Some clinicians rely on screening instruments and diagnostic tools during assessments or may be required to use these tools by an employer. There is a variety of psychometrics available to screen and to measure sexual addiction [1; 10; 36; 37; 38; 39]:

- WASTE-Time Screening Tool
- Sexual Addiction Screening Test (heterosexual/homosexual male and female versions available)
- Sexual Dependency Inventory-Revised
- Sexual Dependency Media Inventory
- Compulsive Sexual Disorders Interview
- Sexual Compulsivity Scale
- Kalichman Sexual Compulsivity Scale
- PATHOS Questionnaire
- Partner Sexuality Survey
- Internet Sex Screening Test

Many of these scales can be accessed online; others must be accessed through academic databases. As an example, the WASTE-Time screening tool consists of items organized into six areas: withdrawal, adverse consequences, inability to stop, tolerance, use of sex as an escape, and time spent on sexual activity (***Table 1***). The tool also allows for follow-up questions.

ONLINE RESOURCES

One of the critical components of conducting a thorough assessment is to ask relevant questions that are designed to elicit a significant amount of usable data. For many, practice is needed in asking the right questions and finding the set of questions that work best to elicit that data.

The Internet can be a useful resource for helping professionals seeking good questions to include in the assessment of sexual addictions. There are numerous 12-step fellowships that address issues of sexual addiction and compulsivity, which will be discussed in greater detail later in this course. Some of these 12-step programs have online self-screening tools to evaluate for problem sexual behaviors.

THE WASTE-TIME SCREENING TOOL FOR SEXUAL ADDICTION

Withdrawal: "Have you experienced any withdrawal symptoms when you are unable to engage in sexual activities?" (Typical responses: Irritability, anxiety, depression, anger, negative mood states, using chemicals to substitute)

Adverse: "Have you ever experienced any negative or adverse consequences as a result of your sexual behaviors?" (Typical responses: Broken relationships, lost career opportunities, financial difficulties, physical injury, and/or psychologic trauma)

Stop (inability to): "Have you attempted to cut back, control, or stop your sexual behaviors without success, even when you know that continuing will cause you harm?" (Typical responses: Multiple attempts at stopping, controlling the addictive behavior without success, even when faced with the knowledge that continuing poses a physical or psychologic problem)

Tolerance or intensity: "Have you found it necessary to increase the amount or intensity of your sexual behaviors to achieve the same effect?"

Escape: "Do you use sexual activity as an escape from negative mood states, such as stress, anxiety, depression, sadness, loneliness or anger?" (Typical responses: Any negative mood state)

Time: "Have you found yourself spending a lot of time preparing for, engaging in, or recovering from sexual activity?" Or, "Have you been spending more time and/or more resources on your sexual activities than you intended?"

A "yes" answer to one item indicates a strong possibility that a sexual addiction is present; further assessment needed. A "yes" answer to two or more items indicates a high probability of sexual addiction; immediate intervention by a trained counselor is needed.

Source: [1] *Table 1*

Although such tools are not clinically validated, they can point toward questions that will elicit the information to make a clinically informed diagnosis. Again, the tools found on these sites are not meant to be clinical.

One tool that may be helpful is The Fourteen Characteristics, published by the 12-step group Sexual Compulsives Anonymous [40]. The Fourteen Characteristics are a set of statements that describe sexually compulsive behavior. Examples include:

- As adolescents, we used fantasy and compulsive masturbation to avoid feelings and continued this tendency into our adult lives with compulsive sex.
- Compulsive sex became a drug, which we used to escape from feelings such as anxiety, loneliness, anger, and self-hatred, as well as joy.
- We tended to become immobilized by romantic obsessions. We became addicted to the search for sex and love; as a result, we neglected our lives.

A client can be given a copy of The Fourteen Characteristics and asked if he or she relates to any of the statements on the list or if any of the characteristics apply. This then leads to a discussion of the compulsive behaviors and how they are affecting the client's life.

One misconception about screening tools is that they are only effective if, after clients check off the relevant items, the score is perfectly diagnostic and provides all of the answers. Although many screening tools and diagnostic tests may be designed this way, other formats can be useful. For instance, checklists can be an excellent portal to obtaining information from the client.

The clinician should always bring up process addictions, including sex addiction, when conducting the addiction assessment on a clinical interview. At the very least, it can be an educational opportunity, as many individuals may be unaware of or have misconceptions regarding these types of addictions. Even if the education is not of direct relevance to the client, it may provide some awareness about other people. Often, this education process, when done in a respectful manner that meets a client where he or she is at during the assessment, can help show a client that has issues about sexuality may be discussed appropriately and comfortably. Even if the client is not willing to open up about his or her sexual behavior in the first session, the educational work can plant some valuable seeds to feel comfortable about opening up later in the treatment process. It is important not to influence or persuade susceptible individuals to a certain conclusion, and of course, maintenance of professional behavior is paramount.

TREATMENT

As previously discussed, the goal of recovery from sexual addiction is never the extreme of deprivation or sexual anorexia. Rather, the general guiding principle is to have recovering individuals put their sexuality into perspective and to learn how to use it in a way that respects themselves and others.

GENERAL PRINCIPLES

As noted, many who are addicted to both drugs/alcohol and sex have identified sexual addiction as the most difficult recovery [9]. When sex addicts attempt to control their disease by "white knuckling," they can be successful for various lengths of time, but this is in essence acting in rather than acting out [26]. Therefore, the basis of sex addiction treatment is similar to the traditional basis for treatment of chemical addictions; quitting "cold turkey," and without help, is never recommended. The Carnes model of sex addiction treatment is eclectic, incorporating educational, behavioral, and psychodynamic components. This will be the model discussed in this course.

Whereas total abstinence from the chemical is recommended in traditional chemical addiction treatment and certain behavioral addiction treatments (e.g., gambling), total abstinence from sex is not necessarily a part of the treatment of sexual addiction. The first part of a successful treatment program for sexual addiction is to cease the acting-out behaviors that are causing the most pervasive problems (e.g., compulsive masturbation, contact with prostitutes, voyeurism, affairs with people other than the spouse). These problems should, of course, be identified in the initial assessment or shortly thereafter. Contracts are often used as part of the treatment process [6]. This is a close parallel to chemical addiction treatment, in which the client is asked to abstain from mood/mind-altering drugs to optimize the effectiveness of the treatment.

Whether sexual addiction is being addressed in an individual counseling office or in a large-scale treatment center, one of the most complicated parts of creating a treatment plan is determining what constitutes a workable treatment goal regarding sexual contact. Some common questions include: Should a sex addict be asked to give up sexual contact with his or her spouse while being treated for the sexual addiction? Is all masturbation off limits? These are difficult questions that must be addressed on a case-by-case basis. A common criticism of addiction treatment in general is that it is too universal in its approach, meaning that the same treatment is often used regardless of substance, compulsion, or manifestation. However, there is no room for this attitude at all in sexual addiction treatment, as the manifestations of the addiction can be so multifarious. Decisions regarding level of sexual contact must also take the treatment setting into account. For instance, a person being treated for sexual addiction in an inpatient setting would be expected to be abstinent from sex with his/her partner because the partner is not there. However, if the person has transitioned to the outpatient level or is being treated exclusively in an outpatient setting, exploring some sexual connection with the partner may be appropriate. The partner's openness to sexuality is another issue altogether.

The masturbation issue is also a delicate one. Of course, there are some religious groups and spiritual approaches that regard masturbation as sinful or ill-advised, so this must be considered when treatment planning with a client. If a client is presenting as a compulsive masturbator, abstaining from the behavior is typically advised, at least until the client can explore other facets of their sexuality and sexual expression. However, in some sexual addiction presentations, masturbation is actually recommended. For instance, if a person, especially a woman, is learning to love herself or view sexual expression in a new way, exploring other avenues of sexual contact may be useful. Some treatment approaches actually encourage clients to re-learn masturbation after they have corrected their core negative beliefs about sex and sexuality. Once again, there is no universal or "best practice" approach here.

TREATMENT PLANNING

Four basic components should be addressed in a treatment plan for sexual addiction. As long as these four components are included, the individualized aims for abstinence of problematic behaviors and resumption (or attainment) of healthy sexuality can be worked in. Clinical discretion regarding how these behaviors are addressed is a must. The four major goals of sex addiction treatment are [1; 6]:

- Improving an addict's overall lifestyle
- Addressing core beliefs about self
- Evaluating core beliefs about sexuality
- Reducing the risk of relapse

These goals are not a step-by-step model, and no one component is more important than another. Rather, they must all work in synchrony to ensure an optimal treatment experience.

Improve an Addict's Overall Lifestyle

The importance of lifestyle change for the addict cannot be overestimated. In 12-step recovery, there is an axiom that an addict must change people, places, and things in order to recover. These are all facets of an individual's lifestyle. In much of the available research of treatment models for recovery (e.g., 12-step, religious, spiritual, rational), there is one major similarity: the necessity of lifestyle change.

In psychologic terms, there are two ways to conceptualize lifestyle. First, lifestyle can be defined as "the typical way or manner of living that is characteristic of an individual or group, as expressed by behaviors, attitudes, interest, and other factors" [3]. Second, Adler's concept of the lifestyle refers to "an individual's characteristic way of overcoming or compensating for feelings of inadequacy" [3]. Adler, who contended that lifestyle originated in childhood, described lifestyle as the pair of eyeglasses through which every individual saw his or her world [41]. Treatment providers' major duty is to help clients acquire a new set of "glasses."

There are a variety of strategies available to assist clients in making a lifestyle change. In some cases, the basic reality therapy strategies of reviewing choices and consequences with the client are very helpful, and use of basic motivational enhancement strategies can augment these reality therapy strategies [75; 76]. Of course, many clients will need to learn healthier approaches to lifestyle, which makes the educational component of treatment important. Client education may be imparted through a lecture at a treatment center or through individual conversations with a client. Some research has shown that art therapy or other creative endeavors can be useful for sexual addicts [77]. In therapy, it is important to use solution-focused strategies to determine which lifestyle changes can be reasonably made.

Groups are an invaluable way for many recovering addicts to acquire new lifestyle skills. Many treatment centers incorporate the use of groups for this very reason. Adjunctive group support, like 12-step groups or alternatives, can also provide a forum for recovering addicts to discuss the acquisition of new habits, patterns, trends, and responses to stressors. There are a variety of ways that new lifestyle skills can be taught and developed. Regardless of the treatment mechanism (or lack of treatment mechanism) used to get sober, lifestyle changes are a critical component of addiction recovery [42; 43]. To bring about this change, an individual will need to access all possible recovery capital. Granfield and Cloud describe recovery capital as [44]:

> The sum total of one's resources that can be brought to bear in an effort to overcome alcohol and drug dependency. It is embodied in a number of tangible and intangible resources and relationships, including those that existed prior to a person's drug involvement, during the period of drug use, and conditions likely to prevail in the future. It encompasses attitudes and beliefs that one has toward the past, present, and the future. It also includes one's mental status and other personal characteristics that can be drawn upon to resolve a dependency problem.

Although their original definition applies to chemical dependency, there are salient comparisons for sexual addiction as well. Although the concept sounds easy—change the lifestyle, change the thinking, change the behavior—as anyone who has worked in the addiction or mental health fields knows, it is never easy. Accessing this recovery capital for meaningful lifestyle change can be nearly impossible for an individual with faulty perceptions about self, others, and surroundings. As Adler suggested, the maladaptive lifestyle is an adaptation to inferiorities that have often been learned in childhood [3]. Thus, the more pervasive the inferiority, typically, the more difficult it is to adapt to the lifestyle change. This is why addressing the next component of the treatment plan, addressing core beliefs about the self, must also be included in the treatment plan for sexual addiction.

Case Study

Patient T is a white man, 42 years of age, and father of five. Twice married, his wife has become increasingly distant from him in their marriage due to her anger and hurt over his use of Internet pornography. Patient T's wife did not know that he used pornography until they were married, and every time she has asked him to stop, his use has only intensified. Now, they have experienced numerous financial consequences because he has reached the credit limit of two of their credit cards paying for pornography. Patient T's wife no longer wants him around their children because she feels that he is a bad influence.

***Comments**: Patient T's pornography use is clearly affecting his life. It has resulted in a damaged relationship with his wife and children, which will take significant work to repair. In addition, the financial cost of the pornography has impacted the financial stability of the family.*

Patient T enters treatment recognizing that he has a problem with pornography and the accompanying compulsive masturbation. This recognition and his willingness to get better are two critical examples of intangible resources. The patient still has his job, which provides him with insurance to access treatment, and his wife has agreed to let him stay in their home while he completes his outpatient treatment (albeit in their basement guest room). These are two major examples of tangible resources. Other resources that can fall into the tangible and intangible categories both are the inspiration that his children provide him and the new friends he has met at 12-step recovery meetings. Patient T does not consider himself a spiritual person, so he does not see praying or contact with God as a resource. Moreover, his mother, who introduced him to pornography at the age of 11, does not feel he has a problem. Patient T was very young when his father left the family, and his mother gave him

pornographic magazines because she felt guilty that a father was not there to teach him about sex. She stays actively involved in the patient's life to the point of enmeshment, and her presence is more of a detriment than it is a resource.

Address Core Beliefs about the Self

As noted, according to Carnes, one of the most commonly held beliefs by sex addicts is that he or she is basically a bad, unworthy person [10]. Indeed, when entering treatment, most addicts have some basic belief of this nature when looking at the wreckage of their lives. However, if an individual has been traumatized and this belief has been ingrained into his or her psyche from an early age, it is hard for any of the good material learned during treatment to stick. In one case study of treatment of a polysubstance and sexual addict with a history of rape, the female addict reflected on the importance of core self-beliefs [45]. During 12 years of treatment attempts (both inpatient and outpatient), all the addict heard was filtered through her core belief of worthlessness. This was a core belief resulting from years of growing up in an alcoholic home and a rape by a family member during her adolescence. Whatever she heard in treatment was tainted by her core negative belief; even if she could change her lifestyle, she was worthless anyway, so it would not matter.

There are a variety of techniques and methods provided in traditional training regarding addressing core negative beliefs. Cognitive-behavioral therapy, reality therapy, and rational emotive behavior therapy, done individually or in a group, have all been used to help people confront their irrational beliefs about self. These standard methods can also work very well with a sex addict [75; 76; 77]. However, those who work with traumatized clients have found that these methods are often insufficient. It may be necessary to incorporate modified psychoanalysis, Gestalt approaches, guided imagery, or newer approaches, such as eye movement desensitization and reprocessing (EMDR), energy psychology, dialectical behavior therapy, and emotional freedom techniques [45; 47; 77]. The use of EMDR in sexual addiction treatment will be discussed in more detail later in this course.

It is important to underscore here that only professionals trained in these specific techniques should utilize them as an element of the treatment plan. If one is not a trained EMDR therapist, EMDR should not be attempted. However, an adjunctive referral for EMDR or other technique may be helpful if the client is experiencing little success with traditional, cognitive approaches.

One major caution about this facet of the treatment plan: addressing core beliefs about the self alone will not make compulsive behaviors disappear. There is an erroneous belief that treatment of the core emotional issue will result in automatic resolution of the presenting problematic behavior (in this case, sexually acting out). Although resolution of core issues is critical to meaningful recovery, it is not a cure all. A person can resolve all of the core issues and do all of the deep healing work that he or she wants, but if strides are not made in the area of lifestyle change, no meaningful, lasting gains will be attained. Moreover, exploring deep issues with a recovering addict who has poor motivation to get better may actually provide him or her with more excuses to continue with the addictive behavior.

Case Study

Patient T's therapist begins to work more in-depth with him; she discovers that he harbors major feelings of unworthiness and "badness," primarily due to his father's abandonment of the family when he was 4 years of age. For all of these years, Patient T has, on some level, believed that it was his fault that his father left, and that because he was unworthy of growing up with a father, he is unworthy of a better life.

***Comments**: Patient T displays core beliefs regarding his own worthlessness and inherent badness, which are common among sexual addicts. These feelings make it difficult for individuals to establish or sustain intimate relationships.*

Evaluate Core Beliefs about Sexuality

Just as sex addicts possess many irrational, negative core beliefs about the self, so too may they possess irrational beliefs about sexuality [21]. As discussed previously, most clients presenting for sexual addiction treatment have not been optimally exposed to healthy beliefs regarding sexuality. This impacts their addiction and, most importantly, their recovery.

Evaluating core beliefs about sexuality is extremely important for the modern generation, which has arguably grown up with an overdose of sexually explicit material. If a sex addict is operating on beliefs about sex learned from watching pornographic videos or viewing pornographic images, serious work must be done in treatment to teach a healthy ideal of sexuality. For instance, pornographic movies are, like any film, constructed using editing and effects, and this can lead to an unrealistic portrayal of sex. When young (or even older) viewers are exposed to these images of "constructed sexuality," they may identify them as an attainable ideal, which they generally are not.

Clinicians have the responsibility to confront these irrational beliefs and to educate. A sense of ease and comfort regarding discussions of sexuality and with one's own sexuality will assist in appropriately and effectively challenging these unrealistic standards. Many of the methods discussed for confronting negative core beliefs about the self can be efficacious in this area as well. However, an added component of psychoeducation is very critical in confronting irrational beliefs about sexuality. In individual counseling, most psychoeducation may be done through conversation, although pamphlets, workbooks, or supplemental materials may also be helpful. At a treatment facility, a psychoeducational lecture on the components of healthy sexuality can be used. Even if a treatment center is solely drug- and alcohol-centered and does not directly address sexuality, presenting such a lecture will be vital for more than a few people in the audience.

Case Study

Like many sex addicts, Patient T believes that sex, specifically orgasm, is his most important need. Remember that the patient's mother gave him his first pornographic materials, telling him directly that she was doing this because he had no father to help him learn about sex. As such, Patient T equated the pleasure that he got from the orgasms with the sense of love and belonging that he was missing from his father. Although he has been good-natured and has always strived to be faithful to the women he was with, Patient T was very promiscuous when he was not in a relationship. When his wife would not be sexual with him, he immediately interpreted this as rejection and that she somehow did not love him. This same issue arose in the client's first marriage. Clearly, all of these beliefs must be confronted in treatment.

***Comments**: It also appears that Patient T has incorrect beliefs regarding sexuality and healthy sexual relationships. Because much of this information was gained in youth, the beliefs may be strongly held, but some education regarding aspects of healthy sexuality would be helpful for this client.*

Reduce Risk of Relapse

For the purposes of this course, relapse refers to any resumption of the primary addictive behavior(s) that cause significant functional impairment in the individual's life. This concept has been defined in numerous ways in the published literature, which has often led to problems in studying the phenomenon [46]. Relapse prevention plans are often discussed as elements of addiction treatment and are essentially proactive steps identified by the client and counselor that the client will take to maintain gains in recovery. Some treatment professionals prefer to refer to these steps as recovery enhancement rather than relapse prevention. While the two terms are basically synonymous, the former reminds recovering individuals that the stronger the recovery system they have in place, the less likely that relapse will occur.

Mental health professionals should delineate certain steps that they expect their clients to take after discharge to maintain the gains achieved during treatment. In the case of inpatient treatment, this may involve meeting one-on-one with clients just prior to discharge to write out a plan for continued care and maintenance of sobriety gains. Often, clients will stop following the plan when they feel "better," and this can lead to an increased risk for relapse.

Some clients take relapse prevention plans very seriously while others do not, but there is no harm in constructing one with a client [74]. Plans can be as specific or as general as warranted by the situation. If used correctly, relapse prevention plans can be recipes for continued success in recovery.

Case Study

Patient T has followed through with his inpatient treatment and has been free of acting out sexually with pornography and compulsive masturbation for the last four months. He has recently become sexual again with his wife. It has been difficult for him to learn and adapt to healthy sexual behavior, but he is committed to maintaining his gains. Patient T and his counselor have made a decision to terminate treatment, largely because he has obtained and has been using a 12-step sponsor. Another contributing factor is that the patient's individual insurance has run out and he does not feel that he can afford to pay for continued counseling on his own, especially because he and his wife have decided to obtain couples' counseling. Patient T's counselor writes a relapse prevention plan, which consists of the following points:

Patient T will attend at least one 12-step meeting per week (in this case, Sexual Compulsives Anonymous) and have contact with his 12-step sponsor by phone no fewer than three times per week.

Patient T will keep the family computer in the public place (e.g., the family room), where it has been since he began treatment. The patient also agrees to keep pictures of his family surrounding the space around the computer.

Patient T will not use the computer if he is experiencing any of the trigger emotions that he discovered in treatment (e.g., anger, frustration, pain, sadness). Instead, the patient will call his sponsor, a member of his support team, or watch sports on television until he can reach someone by phone.

Patient T will keep the enhanced blocking software on his computer at home; only his wife and his sponsor will have access to the password. The patient agrees to let the employee assistance professional contracted by his company make random checks on his computer for the next year.

Patient T will continue working the 12 steps with his sponsor. If his sponsor feels that further outside help is needed, the patient will call his counselor to discuss getting back into individual counseling.

Patient T will continue with couples' counseling sessions with his wife three times per month.

***Comments**: It is vital that sex addicts create a plan to reduce the risk of relapse that addresses their risk factors. In this case, making time spent on the computer a more public activity and providing alternate plans when urges are strongest should help decrease the chance of a relapse.*

APPROACHES TO TREATMENT

According to Earle and Earle, issues of childhood sexual abuse and shame must be dealt with in the treatment process [25]. This is often an important facet of evaluating the core beliefs about the self. Those professionals who feel that dealing with issues of childhood abuse, especially sexual abuse, are outside of their expertise should refer clients to a clinician who is equipped to deal with these issues. Personality disorders and identity issues should also be addressed as part of treatment, as many sexual addiction clients will have signs of entitlement, dependency, and narcissism [26]. When treating impaired professionals for sexual addiction, it is wise to incorporate a third-party evaluator before the individual returns to work [26].

The literature advocates both cognitive-behavioral therapy and psychodynamic techniques as highly effective in treating sexual addiction [1]. Thus, clinicians trained in basic cognitive-behavioral strategies already have many of the tools necessary to treat sexual addiction. The missing piece may be addressing one's own apprehensions about working with issues of sexuality and sexual addiction. All clinicians should engage in self-reflection to evaluate where they stand with issues of sexuality.

Eye Movement Desensitization and Reprocessing (EMDR)

New evidence suggests that EMDR may be a promising intervention in the treatment of sexual compulsivity, sexual addiction, and sexually deviant behaviors [45; 47; 48; 49; 50; 51]. EMDR is a therapy originally developed for post-traumatic stress disorder (PTSD). Eye movements or alternate forms of bilateral stimulation are used to accelerate the body's inherent information processing system and ultimately shift traumatic memories to a more adaptive state in the brain. EMDR uses a comprehensive, eight-phase therapeutic approach; desensitization constitutes only one of the phases [52]. EMDR has been exhaustively studied and determined to be an efficacious PTSD treatment by several major clinical bodies [53; 54; 55; 56; 57]. Since its development in 1987, EMDR has been effectively utilized with a variety of clinical presentations related to anxiety and other forms of psychopathology (e.g., social phobias and depression) connected to unresolved antecedent memories [58].

Moskovitz, an expert in borderline personality disorder, described EMDR as, "an artful blend of several therapeutic techniques, including exposure therapy, cognitive therapy, and even an abbreviated form of the free association of psychoanalytic psychotherapy" [59]. EMDR is an integrative therapy, and the eye movements or other bilateral stimulation appear to affect the brain in a more dynamic way than traditional approaches and has a greater impact [78]. EMDR protocols can be altered to target core cognitions (etiologic) or urges (behavioral). EMDR is being offered by almost every major treatment center in the United States with a specified program for sexual addiction. The holistic nature of EMDR and similar therapies makes it especially attractive in the treatment of sexual addiction, specifically in the areas of the treatment plan model that address core beliefs.

Although EMDR may be a promising advancement in the treatment of sexual addiction, it is important to remember that EMDR should not be attempted by clinicians without specific training. Collaborative referral is always an option. The EMDR International Association provides a complete listing of certified EMDR therapists throughout the world on their website at https://www.emdria.org. The same website also provides more information about EMDR and training opportunities.

Support Groups

Clinicians are strongly advised to refer recovering sex addicts to a 12-step support group such as Sex and Love Addicts Anonymous or Sexual Compulsives Anonymous [1]. Of course, there is controversy on this topic, as not every clinician is an advocate of 12-step programs. Regardless of the level of group support used, it can be an invaluable resource for recovering addicts, and there are non-12-step programs available. As discussed previously, sexual addicts notoriously struggle with intimacy. These struggles are generally not exclusive to romantic relationships but apply to friendships and other interpersonal relationships as well. Thus, it is recommended that sex addicts develop meaningful interpersonal relationships that are not sexual in nature in order to gain a better understanding of and appreciation for intimacy. If healthy friends or non-shaming church support groups are not available to the addict, 12-step groups are the most widely available solution.

The most well-known 12-step groups are the originals: Alcoholics Anonymous for alcoholics and Narcotics Anonymous for chemical addicts. There are countless other spin-off programs to address various addictions. Interestingly, there are quite a few sex-focused programs to choose from, mostly due to variations in definitions of sexual addiction and sexual sobriety from program to program. Not every program will be available in every area, and even if there is availability, it is imperative to guide clients to the program best suited for them. Family members and friends of addicts may also be referred to one of several groups for family members of sex addicts.

Sexual Compulsives Anonymous

Sexual Compulsives Anonymous takes a very liberal, accepting view of members. According to their website, Sexual Compulsives Anonymous is a 12-step fellowship, inclusive of all sexual orientations, open to anyone with a desire to recover from sexual compulsion [40]. It is not group therapy, but a spiritual program that provides a safe environment for working on problems of sexual addiction and sexual sobriety. Members are encouraged to develop their own sexual recovery plan and to define sexual sobriety for themselves.

Sexual Addicts Anonymous

Sexual Addicts Anonymous (SAA) offers a similar level of tolerance and acceptance as Sexual Compulsives Anonymous. According to their website, "membership is open to all who share a desire to stop addictive sexual behavior" [60]. The goals of Sexual Addicts Anonymous are to become sexually healthy and to help other sex addicts achieve freedom from compulsive sexual behavior. COSA (previously referred to as Codependents of Sex Addicts or Co-Sex Addicts) is the companion program to SAA.

Sex and Love Addicts Anonymous

Sex and Love Addicts Anonymous embraces the progressive diseases model. Founded in the late 1970s by an addict who found that his sex and relationship addiction issues could not be adequately addressed in Alcoholics Anonymous, this fellowship allows for emphasis on love addiction as a separate or a combined construct [28]. Co-Sex and Love Addicts Anonymous is the family and friend program associated with Sex and Love Addicts Anonymous.

Sexaholics Anonymous

Sexaholics Anonymous takes a more conservative view of sexual recovery and is often embraced by individuals who are more religious. According to their website, "for the sexaholic, any form of sex with one's self or with partners other than the spouse is progressively addictive and destructive" [61]. According to this group, lust is the driving force behind sexual acting out and true sobriety includes victory over lust. For members of Sexaholics Anonymous, masturbation is not tolerated in a recovery program. S-Anon is the fellowship of family and friends of sexual addicts who participate in Sexaholics Anonymous; both are considered more conservative groups.

Sexual Recovery Anonymous

Sexual Recovery Anonymous also takes a more conservative view. According to their website, sexual sobriety is "the release from all compulsive and destructive sexual behaviors" [62]. Like Sexaholics Anonymous, members of this group believe that sobriety includes freedom from masturbation and sex outside of a mutually committed relationship.

Recovering Couples Anonymous

Recovering Couples Anonymous is a program open to couples in all forms of addiction recovery. Although the program is not widely available in every geographic area, they offer teleconferencing meetings on a weekly basis.

Alternative Groups

There are alternatives to 12-step support groups, and it is important that each client's needs are met by the group chosen. One of the best-known alternatives to 12-step groups is LifeRing Secular Recovery, which offers peer support and positive connections for people in recovery, but with no spiritual focus [63]. Although these meetings are not readily available throughout the country, their website provides several other meeting formats (e.g., online, printed).

Be prepared to orient clients about meetings and warn them that everyone may not be there for the same reasons. There are men-only, women-only, and gay and lesbian groups of the various fellowships. Once again, it is important to individualize treatment and to discuss the benefits and risks of same gender meetings.

ISSUES FOR CLINICIANS

Graduate study in human sexuality is encouraged for counselors, and an understanding of healthy sexuality is vital for those treating sexual addiction. Sadly, most graduate programs do not include coursework on healthy sexuality or sexual addiction [1]. As Hagedorn and Juhnke cautioned, "If counselors do not receive the proper training in the treatment of sexual addiction, clients, and those affected by their addicted behaviors, will be the ones adversely affected" [1].

In addition to more extensive education, clinicians may benefit from networking with other professionals in the community. This networking is especially important for clinicians who make referrals for specific treatment. Colleagues who are comfortable treating sexual addiction and local treatment centers equipped to address sex addiction can be identified, allowing for better referral and education for clients.

As discussed, examining one's own attitudes about sex and sexuality is critical in working with individuals who are struggling with any of the issues of sexual addiction. The same applies when working with the family or partner of a sex addict. Questions that may help guide this self-reflection include:

- What are my attitudes about sex that may block my effectiveness in handling the issues involved in sex addiction?
- Do I feel comfortable/competent to clinically handle the issues of sexuality and sexual addiction?
- What are areas of my own sexuality that I may still need to explore?

Of course, this is a personal decision on your part. This personal exploration is a solid investment for any clinician interested in working with sexual addiction.

RESOURCES

Sex and Love Addicts Anonymous
https://slaafws.org

Sex Addicts Anonymous
https://saa-recovery.org

Sexual Recovery Anonymous
https://sexualrecovery.org

Sexaholics Anonymous
https://www.sa.org

Sexual Compulsives Anonymous
https://sca-recovery.org

International Institute for Trauma and Addiction Professionals (IITAP)
https://iitap.com

Society for the Advancement of Sexual Health
https://www.sash.net

International Service Organization of COSA
https://cosa-recovery.org

CONCLUSION

This course is not meant to prepare all clinicians to exclusively provide sexual addiction treatment. Rather, it is the intent of the course to educate clinicians to work with sex addicts in a clinical setting. Above all, it is vital that mental health providers be comfortable with discussions of sexuality and assessing for problematic sexual behaviors. Clients will benefit from a clear and nonjudgmental approach to issues surrounding sexuality and sex addiction. Furthermore, knowing when and where to make referrals is an important aspect of client care. Providing clients with accurate information regarding healthy sexuality and conducting a thorough sexual history will benefit clients and, ultimately, improve the quality of the client-clinician relationship. This area of study is ever-evolving, and clinicians are encouraged to continue their learning with online resources and emerging literature.

GLOSSARY OF TERMS

Addiction: Continuing to engage in a behavior even when the activity causes repeated pain and consequences [7]. Addiction usually implies a holistic impact on a person as a result of continuing to engage in the harmful behavior.

Anonymous sex: Becoming sexually aroused through having sex with strangers; a class of Carnes' sexually addictive disorders.

Codependency: A relationship in which one partner is psychologically attached in an unhealthy way to an addicted partner and/or that partner's addictions.

Compulsive behaviors: Behaviors or mental acts engaged in to reduce anxiety or stress.

Exhibitionist sex: Sexual arousal through flashing sexual parts of the body in public; shock value is typically a large part of the arousal. A class of sexually addictive disorders identified by Carnes and a paraphilia according to the DSM-5-TR [5; 21].

Exploitative sex: Forcing another person to engage in sexual contact (e.g., sexual assault, rape, sex with children); a class of sexually addictive disorders and potentially a paraphilia [5; 21].

Fantasy sex: Obsession with sexual fantasy rather than the reality of genuine, intimate sexuality (including feelings, behaviors, and relationships); a class of sexually addictive disorders [21].

Impulsive behaviors: Behaviors that display little to no forethought, reflection, or consideration of consequences.

Intrusive sex: Touching others in a sexual way without consent; may involve the use of power and authority (e.g., sexual abusive dynamics, sexual harassment dynamics). A class of sexually addictive disorders [5; 21].

Masked grief reactions: The idea that maladaptive behaviors (including addictions) can be a response to unaddressed grief or losses.

Moral model: The view that alcoholics and addicts are somehow morally flawed and that repentance, conversion, or total commitment to a religious program will address the sin and solve the problem.

Nongenital sexuality: The exploration of all the ways to be sexual without being genital [21].

Pain exchange: The giving or receiving of pain for sexual pleasure; also known as sadomasochism. A class of sexually addictive disorders and paraphilias [5; 21].

Paraphilia: The classification of unusual and typically harmful sexual behaviors as diagnosable mental illnesses according to the DSM-5-TR (e.g., voyeurism, pedophilia, sadism, masochism) [5].

Partner sexuality: Intimacy with a partner that is clearly erotic [21].

Paying for sex: Sexual activity that involves an exchange of monetary currency (e.g., prostitution, phone lines); a class of sexually addictive disorders [21].

Relationship sexuality: Ability to sustain warm and caring friendships that are not erotic with both the same and opposite sex [21].

Seductive role sex: Manipulating others into sexual contact; involves treating the other person as a "conquest" or a challenge rather than an intimate connection. A class of sexually addictive disorders [21].

Sense of self: Capacity to know and express desires, wants, and areas of discomfort [21].

Sensuality: Awareness of senses (e.g., temperature, texture, color, sound, taste, smell) [21].

Sexual addiction: Pattern of maladaptive sexual behaviors, cognitions, belief systems, consequences, and effects on others [4].

Sexual anorexia: An obsessive state in which the physical, mental, and emotional task of avoiding sex dominates one's life.

Sexual compulsivity: Out of control sexual behavior, usually engaged in as a coping mechanism.

Sexual impulsivity: Sexual behavior that displays little to no forethought, reflection, or consideration of consequences.

Spiritual sexuality: Sexuality as an extension of the search for meaning and spirituality; a search shared with a partner [21].

Trading sex: Sexual activity that involves an exchange of goods or services (e.g., trading sex for drugs); a class of sexually addictive disorders [21].

Voyeuristic sex: Sexual arousal from observing other people engaged in sexual activity rather than engaging in sexual contact; a class of sexually addictive disorders and a paraphilia [5; 21].

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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Evidence-Based Practice Recommendations Citation

Brook G, Church H, Evans C, et al. 2019 UK national guideline for consultations requiring sexual history taking: Clinical Effectiveness Group British Association for Sexual Health and HIV. *Int J STD AIDS*. 2020;31(10):920-938. Available at https://www.bashhguidelines.org/media/1241/sh-guidelines-2019-ijsa.pdf. Last accessed March 29, 2023.