Treating the Sexually Addicted Client: Establishing a Need for Increased Counselor Awareness

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Seventeen to 37 million Americans struggle with sexual addictions (P. Carnes, 1994b; A. Cooper, D. L. Delmonico, & R. Burg, 2000; B. Morris, 1999; & J. L. Wolf, 2000), yet traditionally trained addictions and offender counselors often find themselves unprepared to assist clients who are sexually addicted. This article provides a general overview of the disorder, explores the ongoing definition debate, and offers clinically proven treatment protocols.

The suggested prevalence of sexual addiction is staggering. An estimated 17 to 37 million Americans struggle with this addictive disorder (Carnes, 1994b; Cooper, Delmonico, & Burg, 2000; Morris, 1999; Wolfe, 2000). These figures are greater than the combined number of Americans who are addicted to gambling or have eating disorders (National Center on Addiction and Substance Abuse at Columbia University, 2003; Potenza, Fiellin, Hening, Rounsaville, & Mazure, 2002; Shaffer & Korn, 2002; Tenore, 2001). In addition to the prevalence, the incidence of sexual addiction is rising, due in part to the affordability, accessibility, and anonymity of sexually explicit material available on the Internet (Cooper et al., 2000). The prevalence of sexual addiction is predicted, based on current trends, to continue rising at a rapid rate (Cooper, 2004).

Because of the lack of qualified counselors, many addicted individuals turn to self-help groups, all of which are administered by nonprofessionals without formal education and training in treating sexual addiction (Haugh, 1999; Myers, 1995; Wolfe, 2000). Of the 73 nationally known 12-step, self-help support groups, 8 distinct groups are dedicated to individuals seeking assistance in managing their sexually addictive behaviors. This number of sexual addiction support groups is more than any other 12-step group addressing an addictive disorder and may reflect the large number of individuals who are sexually addicted. Despite steadily in-
creasing self-referral and participation in 12-step, self-help groups such as Sexaholics Anonymous, Sex and Love Addicts Anonymous, Sex Addicts Anonymous, Sexual Compulsives Anonymous, and Sexual Recovery Anonymous, the treatment community lacks the resources and funding to address this growing population (National Council on Sexual Addiction and Compulsivity, 2000).

Although the increase in the number of 12-step groups specific to the treatment of sexual addiction is a commendable step, there is a growing need for addictions and offender counselors to respond to the needs of the population of clients who are sexually addicted. Although a very limited number of articles related to sexual addiction have been published, these articles have typically been published in journals specific to other clinician groups. For example, Carnes (1990) presented his early findings in the American Journal of Preventive Psychiatry & Neurology, Goodman (1993) offered a definition and some treatment suggestions in the Journal of Sex and Marital Therapy, and Myers (1995) explored the impact of addictive sexual behavior in the American Journal of Psychotherapy. A specific journal, Sexual Addiction & Compulsivity, was created in 1993 to provide a forum for authors and researchers to provide information regarding sexual addiction (e.g., Delmonico & Griffin, 1997; Goodman, 2001; Manley & Koehler, 2001; Ragan & Martin, 2000). Whereas this demonstrates the importance and timeliness of information pertinent to treating clients who are sexually addicted, this information has been disseminated to most clinician groups, with the exception of addictions and offender counselors. Psychiatrists, sex and marital therapists, psychotherapists, even those working specifically with sexual addicts, all have the necessary scholarly resources at their disposal to aid in their work with this client population. As of yet, no meta-analysis defining sexual addiction and outlining the recommended treatment protocols has been published for addictions and offender counselor generalists who are not specialists working exclusively with couples or persons who are sexually addicted. Concomitantly, no meta-analysis defining sexual addiction has been published in the Journal of Addictions & Offender Counseling. Therefore, the intent of this article is to (a) define this disorder according to the existing literature; (b) establish the need for professionals working in the addictions and criminal justice fields to know about sexual addiction; and (c) offer clinically proven treatment protocols to assist with the assessment, diagnosis, and treatment of clients who are sexually addicted.

**Defining Sexual Addiction**

Patrick Carnes (1994b), a pioneer in the sexual addiction field since 1976, noted that compulsive sexual behaviors resembled the progressive and chronic compulsive behaviors commonly found with other addictions. For this reason, Carnes chose to use the term *sexual addiction* to describe a set of maladaptive behaviors that were uncontrollable, that brought negative consequences upon the addicted individual, and that harmfully affected those involved with the addicted individual. He further noted that, similar to the early days when public education on alcoholism spurred both ignorance and prejudice, controversy about the use of the term *sexual addiction* was to be expected.
Controversy has indeed ensued. Terminology and diagnostic criteria for sexual addiction have undergone considerable scrutiny and debate (Apt & Hulbert, 1995; Coleman, 1990; Goodman, 2001; Schneider & Irons, 1996). Although scholarly debate can be an impetus for improved training and treatment regimens, it can also impede the delivery of necessary resources to individuals in crisis: This has occurred in the debate over sexual addiction. The resources and energy needed for training new counselors, conducting empirical research, and creating new treatment protocols and facilities have been stymied over the legitimization of the disorder (Goodman, 2001; Manley & Koehler, 2001; Wolfe, 2000).

Before treatment protocols are explored, the continuing debate must be addressed to help validate our suggestions. Therefore, we explore (a) the addictive disorder; (b) criteria development for the designation of an addictive disorder; and (c) the literature-based debate over the use of the term addiction to describe maladaptive, compulsive-like sexual behaviors.

The Addictive Disorder

The model on which this article is based is that of the addictive disorder (Carnes 1994b; Goodman, 2001). This model assumes that compulsive-like behavioral manifestations that meet criteria similar to those for chemical dependency are in fact addictive behaviors. Researchers (Goodman, 1998; Griffin-Shelley, Sandler, & Lees, 1992; Raviv, 1993) have stressed the importance of understanding addiction in a broader context than that of strictly chemical dependency. Although some researchers and counselors in the addictions field (Apt & Hulbert, 1995; Barth & Kinder, 1987; Levine & Troiden, 1988; Rachlin, 1990) believe that the term addiction should be applied only to circumstances that involve chemical substances, similar diagnostic criteria have been applied to a number of problem behaviors, often called “process addictions.” These addictions include those related to sex (Abouesh & Clayton, 1999; Carnes, 1992, 1994a, 1994b; Fischer, Williams, Byington, & Lonsdale, 1996; Goodman, 1993, 1998, 2001; Levin, 1999), gambling (Buchta, 1995; Griffiths, 1992), eating (Baker, 1995; Sheppard, 1995), work (Robinson, 1998, 2000), television (McIlwraith, 1998), shopping (Lee, Lennon, & Rudd, 2000), exercise (Cockerill & Riddington, 1996), the Internet (Armstrong, Phillips, & Saling, 2000; Young, 1999), and video games (Griffiths, 1991, 1997).

Diagnostic criteria for addiction are often applied to provide a framework for treatment because clients seldom present with a singular addictive disorder (Das, 1990; Merta, 2001; Rowan & Galasso, 2000). It seems prudent, as well as cost-effective, to treat multiple addictions simultaneously so as not to repeat therapeutic interventions for each disorder (Juhnke, 2002). Because the same interventions used with chemical dependency have proven effective in treating other addictive disorders (Griffin-Shelley et al., 1992), and given that many who are chemically addicted also meet sexual addiction criteria (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Carnes, 1992; Delmonico & Griffin, 1997), it follows that those trained to treat chemical dependency should also be trained to treat the commonly comorbid sexual addiction.
Criteria Development for the Addictive Disorder

In working toward defining the addictive disorder, Carnes (1992), Goodman (1998, 2001), Levin (1999), and Young (1999) suggested that one begin by identifying the key elements used to identify chemical dependency. The fact that neither tolerance nor withdrawal is necessary for designating a behavior or substance as addictive (American Psychiatric Association [APA], 2000; O’Brien, 1996; Potenza et al., 2002) is an issue that we address in more detail later in this article. Therefore, we begin with the conditions that are both necessary and sufficient for the diagnosis of a dependence/addictive disorder.

Goodman (2001) suggested that the two criteria necessary and sufficient for the designation of drug addiction are “(1) recurrent failure to control the use of one or more drugs, and (2) continuation of drug use despite substantial harmful consequences” (p. 195). To arrive at a concise definition of an addictive disorder, Goodman (a) substituted the word behavior for drug in the above conditions and (b) added key elements from those arguments asserting that addictive behaviors are better defined within the context of a compulsion or an impulse control disorder. An addictive disorder can therefore be defined as

A behavior that can function both to produce pleasure and to reduce painful affects is employed in a pattern that is characterized by two key features: (1) recurrent failure to control the behavior, and (2) continuation of the behavior despite substantial harmful consequences. (p. 195)

Similar definitions have been applied to designate gambling (Blaszczynski, Buhrich, McConaghy, 1985; Buchta, 1995; Griffiths, 1992; Potenza et al., 2002), the Internet (Armstrong et al., 2000; Young, 1999; Young, Pistner, O’ Mara, & Buchanan, 1999), and eating disorders (Baker, 1995; Flood, 1989; Sheppard, 1995) as addictive disorders.

If one accepts the merits of this definition for an addictive disorder, the next step is to specify diagnostic criteria. In developing such criteria, Goodman (1993), Levin (1999), and Young (1999) began with comparing the criteria for compulsive gambling with the criteria established for substance dependence as found in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM–IV–TR; APA, 2000). In addition to the diagnostic criteria noted by each of these authors, they also noted three additional elements of sexual addiction, namely, the factor of secrecy, the use of sex as an escape from dysphoric mood states, and the likelihood of engagement in illegal activities in pursuit of one’s addiction. Goodman (2001) then combined the criteria and substituted the term behavior for the terms substance and substance use found in the substance dependence criteria. In addition, “characteristic withdrawal syndrome for the substance” (APA, 2000, p. 197) was replaced with a more universal definition for withdrawal that applied to all addictive behaviors.

We therefore suggest that the following set of criteria be accepted as clinically relevant for diagnosing an addictive disorder:

A maladaptive pattern of behavior, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

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A maladaptive pattern of behavior, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
1. tolerance, as defined by either of the following:
   a. a need for markedly increased amount or intensity of the behavior to achieve the desired effect
   b. markedly diminished effect with continued involvement in the behavior at the same level or intensity
2. withdrawal, as manifested by either of the following:
   a. characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the behavior
   b. the same (or a closely related) behavior is engaged in to relieve or avoid withdrawal symptoms
3. the behavior is often engaged in over a longer period, in greater quantity, or at a higher intensity than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control the behavior
5. a great deal of time spent in activities necessary to prepare for the behavior, to engage in the behavior, or to recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of the behavior
7. the behavior continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the behavior (Goodman, 2001, pp. 195–196)

To conclude, the establishment of diagnostic criteria appears to have several merits including, but not limited to, the creation of common clinical language, a legitimization of the disorder for the purposes of third-party reimbursement, and a step toward a standardized treatment protocol.

The Addictive Disorder Debate

To address the validity of using the addictive disorder model for this article, it is necessary to address the literature that discounts, as well as affirms, sexual behavior as addictive. Whereas there is a plethora of literature that debates the merits of designating these addictive behaviors as compulsions (e.g., Abouesh & Clayton, 1999), impulses (e.g., Hollander & Rosen, 2000), or paraphilias (e.g., Kafka, 1997), the arguments addressed herein involve issues of dependence (e.g., physical withdrawal and tolerance) and recovery.

In arguing against acknowledging sex as addictive, many authors address the physical dependence criteria often found with addictive substances. Apt and Hulbert (1995) asserted that “A true addiction involves a physiological dependence on a particular substance that results from the habitual use of that substance. Sex is a form of interaction, not a substance on which the body comes to depend” (p. 104). Levine and Troiden (1988) made similar claims in advocating for the retention of the term addiction for chemical substances when they added, “Although sexual experiences may be ‘mood altering,’ abrupt withdrawal from sexual behavior does not lead to forms of physiological distress such as diarrhea, delirium, convulsions, or death” (p. 357). Finally, Barth and Kinder (1987) declared that any similarities between sexual and chemical addiction do not overrule the original definition of addiction as a physiological dependence on a foreign substance, evidenced by the removal of that substance producing a physiological withdrawal state. Sexual impulsivity involves no foreign substances or withdrawal states, and as such should not be labeled as an addiction. (p. 21)
The main argument made by these authors is that for a behavior/substance to be addictive, it must meet criteria for physical dependence, criteria exhibited by tolerance and withdrawal.

Although these arguments may have had merit in the past, current research refutes such assertions. O’Brien (1996) stated that “Modern concepts of addictive disorders emphasize the compulsive and relapsing drug-taking behaviors rather than tolerance and physical dependence” (p. 677). Potenza et al. (2002), through a comprehensive study discussing the merits of designating gambling as an addictive disorder rather than as an impulse control disorder, found that behavioral addictions can be “considered an addiction without exogenous substance use” (p. 722).

The DSM–IV–TR (APA, 2000) lists substances such as cannabis, cocaine, and hallucinogens, all of which have dependence criteria. It is interesting that none of these substances cause physiological dependence but that all are considered “addictive” substances based on psychological dependence. Because maladaptive patterns of chemical use must meet 3 of 7 criteria to be designated as a dependence (versus abuse), it is likely that an individual can experience dependence without undergoing tolerance and withdrawal. In fact, according to the DSM–IV–TR, “Neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence” (APA, 2000, p. 194).

Typical withdrawal symptoms from such substances as caffeine, cocaine, and marijuana include the following: anxiety; depression; suicidal ideations; dysphoric mood states; irritability; changes in appetite; sleep disturbance; fatigue or drowsiness; cravings; and significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000). These same withdrawal symptoms are seen in those who cease sexually addictive behavioral patterns (Carnes, 1994b; Goodman, 1998; Levin, 1999). Even opponents Levine and Troiden (1988) noted the high levels of anxiety experienced by sexual addicts in withdrawal. Although sexual addiction does not involve the ingestion of a foreign substance, the behavior patterns noted by Carnes (1992, 1994b), Goodman (1993, 2001), and others appear to meet the criteria necessary for psychological dependence and withdrawal as noted by the DSM–IV–TR (APA, 2000).

The other primary argument against classifying problematic, compulsive-like sexual behaviors as addictive concerns the issue of recovery from this disorder (Apt & Hulbert, 1995; Barth & Kinder, 1987; Levine & Troiden, 1988). The majority of treatments for addictive disorders call for lifetime abstinence from all addictive substances, but individuals who are sexually addicted are not expected to abstain from having sex (Barth & Kinder, 1987; Goodman, 2001; Willenbring, 2000). Apt and Hulbert (1995) claimed,

A person with a sexual addiction is seldom urged to forgo sex entirely. Instead, he or she is usually encouraged to find other, more appropriate forms of sexual expression. A person with a drug addiction is cured when he or she gives up the substance; a person with an addiction to sex is cured when he or she confines his or her sexual activities to a culturally sanctioned pattern, such as a long-term relationship in which there is emotional intimacy and sexual reciprocity. (p. 104)
Apt and Hulbert further contended that the only path to recovery for sexual addiction, similar to chemical addiction, is through total abstinence. Because this goal is not often the focus of treatment for sexual addiction (Carnes, 1992), opponents to the addictive disorder model discount the addictive nature of sex.

In response to the need for total abstinence as defined by the previously reviewed research, Goodman (2001) and Willenbring (2000) suggested a closer examination of the definition and goal of abstinence. Although many of the 12-step fellowships call for total abstinence from all mood-altering drugs, the reality is that many individuals in recovery routinely ingest substances either for pleasure (e.g., caffeine and nicotine) or for mental health purposes (e.g., Prozac for depression). Goodman (2001) recommended investigating what “functional qualities of unacceptable drugs make them unacceptable” (p. 202). An “unacceptable” drug for a given individual would therefore be defined by that individual’s propensity to use that drug addictively (as defined by a failure to control the use of the drug and continued use despite negative and harmful consequences). Therefore, Goodman’s (2001) recommended definition for drug abstinence would be “Abstaining from (not using) any drug that would be likely to be engaged in addictively” (p. 202). When defined in this manner, abstinence from sexual addiction would involve abstaining from any sexual behavior that results in (a) a failure to control that behavior or (b) the continuation of the behavior despite negative consequences. When abstinence from addictive behavior is understood in this context, lifetime abstinence from sexual addiction is more easily understood and attainable.

To conclude the discussion of the addictive disorder, we want to emphasize that not all compulsive-like sexual behaviors are best explained as addictions. Whereas similar behaviors can be part of ongoing personality disorders, obsessive/compulsive disorders, sexual paraphilias, or other disorders, the lack of a separate diagnosis for an addictive disorder (with accompanying criteria) leaves counselors without relevant and appropriate diagnostic and treatment options.

A Fundamental Understanding of Sexual Addiction

It is imperative that addictions and offender counselors have a fundamental understanding of sexual addiction. This is especially true for counselors working with chemically addicted and court-referred clients. First, given that addicted persons often exchange one addiction for another, and because of the high comorbidity between chemical and sexual addictions, counselors must be able to recognize the presence of addictive behaviors (e.g., sexual) and intervene efficiently. Addictions professionals stand the risk of misdiagnosing clients when they assume chemical dependency independent of other addictive behaviors (Manhal-Baugus, 1996). In reality, there may be underlying sexual compulsions driving the overt and readily identifiable secondary, chemical addictions (Peck, 1993). Clients often first acknowledge these secondary, chemical addictions because such additions are more socially acceptable than sexual addictions. Additional reasons for increased professional awareness of sexual addiction include the comorbidity between psychiatric disorders and sexual
addiction and the efficacy of using a sexual addiction recovery model with incarcerated individuals.

**The Relationship Between Chemical and Process Addictions**

Several studies have demonstrated the clear relationship between chemical and process addictions. Das (1990) demonstrated the connection between excessive drinking, overeating, and compulsive gambling. Merta (2001) noted the comorbidity of chemical dependency and such behaviors as compulsive eating, gambling, and compulsive shopping. Rowan and Galasso (2000) showed the connection between gambling and alcoholism, as did Ledgerwood and Downey (2002) and Potenza et al. (2002). Other studies have discussed cross-addiction in even greater detail (see Buck & Sales, 2000; O’Brien, 1996; Raviv, 1993).

Griffin-Shelley et al. (1992) studied chemically dependent adolescents admitted to a dual diagnosis inpatient psychiatric hospital. Of the adolescents who participated in the study, 91% reported being drug dependent. Of these participants, 100% reported concurrent nicotine addiction, 87% reported concurrent relationship dependency, 82% reported concurrent alcohol dependency, 74% reported concurrent compulsive sexual behaviors, 61% reported concurrent eating disorders, and 18% reported concurrent compulsive gambling. Although there are many additional studies that confirm the connection between chemical and process addictions, the comorbidity of chemical and sexual addiction is of particular interest in this article.

Carnes (1992) conducted a comprehensive study of individuals who were sexually addicted and found high rates of comorbidity between sexual addiction and other addictions. Carnes found in his participant sample that 42% of individuals who were sexually addicted were also chemically dependent, 38% had a comorbid eating disorder, 28% had issues with compulsive working, 26% were compulsive spenders, and 5% were compulsive gamblers. Delmonico and Griffin (1997) identified comorbid addictions to drugs, spending, eating, and gambling among the sexually addicted sex offenders whom they studied. Young et al. (1999) surveyed therapists who had treated clients who had addictive cyber-related disorders and validated the connection between chemical and sexual addiction by highlighting the similar statistics, behaviors, and interventions used for both types of addiction.

In a related study, Black et al. (1997) described the sociodemographic, phenomenology, and psychiatric comorbidity of individuals responding to an advertisement for persons suffering from problems with compulsive sexual behavior. They found that a high number of participants also had chemical addictions. These authors also justified the use of the term sexual addiction and alluded to the complications involved with the psychiatric comorbidity with this type of addiction.

If one accepts that during their career counselors are likely to encounter a client struggling with substance abuse, compulsive gambling, or an eating disorder, it seems practical to equip them with the knowledge and skills necessary to treat these disorders concurrently. Given that sexual addiction is often comorbid with these and other addictive disorders, it is not sensible for counselors to be adept at assess-
ing and treating one disorder (e.g., chemical dependency) without understanding the impact of comorbid disorders. Raviv (1993) concluded that “Psychotherapists need also to be aware of the phenomenon of multiple addictions and of the fact that many of their addicted patients are simultaneously addicted to more than one type of substance and/or dysfunctional behavior pattern” (p. 28).

**The Relationship Between Psychiatric Disorders and Sexual Addiction**

In addition to comorbid addictive disorders, sexual addiction is often found in conjunction with common psychiatric disorders. Many authors (Carnes, 1994a; Manley & Koehler, 2001; Ragan & Martin, 2000) describe the complications in assessing the presence of sexual addiction because it is often hidden, intentionally or not, behind other presenting issues, such as depression, suicide attempts, or anxiety.

Ragan and Martin (2000), in describing the psychobiology of sexual addiction, noted the psychiatric comorbidity between sexual addiction and disorders such as depression and anxiety. Delmonico and Griffin (1997) identified feelings of hopelessness, helplessness, despair, and shame among studied individuals. In comparing three groups (i.e., sexual addicts, pathological gamblers, and nonaddicts), Raviv (1993) found that not only were sexual addicts significantly more anxious, depressed, and obsessive-compulsive than the nonaddict control group, but they were also significantly more depressed than the pathological gamblers. Finally, Carnes (1994a) found that sexual addiction often accompanies such disorders as paranoia, depression, suicidal ideations, mania, anxiety, and obsessive-compulsiveness.

Additional studies that demonstrate common comorbid disorders with sexual addiction have been mentioned throughout this article. The purpose of highlighting these connections is the following: If counselors are exposed to these disorders in their formal graduate training and are not prepared for the possibility of an underlying, exacerbating, or comorbid sexual addiction, treatment outcomes will likely be affected.

**Working With Incarcerated Individuals**

Educating counselors about sexual addiction will also assist those who work with incarcerated individuals, particularly sexual offenders. Several studies (Tays, Earle, Wells, Murray, & Garrett, 1999) have demonstrated the efficacy of using a sexual addiction recovery model with sexual offenders. Fischer et al. (1996) conducted a program evaluation using a pre- and posttest design for counselors who worked primarily with clients referred from the judicial system. The goals of the program were to increase the understanding of the process of sexual addiction, to differentiate between sexual addicts and sexual offenders, and to describe the recovery process. The differences in pre- and posttest scores showed a consistent positive change toward increased counselor understanding and empathy for the offender who was sexually addicted.

Delmonico and Griffin (1997) called for the sexual addiction and sexual offender treatment fields to bridge differences between the assessment and treatment
modalities used by each field. These authors proposed a four-quadrant model to assist the counselor with recognizing problematic sexual behavior. This model differentiated the sexually addicted sex offender, the sexual offender, the sexual addict, and the sexually concerned. Client characteristics, presenting behavior patterns, and treatment protocols were offered within each category. The authors concluded that without proper understanding and training, counselors cannot offer their clients the most beneficial treatment.

**Treatment Protocols for Working With Clients Who Are Sexually Addicted**

Through a comparative analysis between the work done by the U.S. Department of Health and Human Services (DHHS; 1998) in developing competencies for working with chemically addicted clients, our combined 23 years of extensive clinical experience, and the work done by prominent researchers and counselors in the sexual addiction field (most notably Carnes, 1994a, 1994b; Myers, 1995; Schneider, 2000; Seligman & Hardenburg, 2000), we now turn to the necessary treatment components for professionals likely to encounter clients who are sexually addicted. These treatment dimensions include (a) clinical evaluation; (b) treatment planning; (c) referral; (d) service coordination; (e) counseling; (f) client, family, and community education; (g) documentation; and (h) professional and ethical responsibilities.

**Clinical Evaluation**

The clinical evaluation process involves both client screening and assessment (DHHS, 1998). In this phase, the client, counselor, and significant others determine the most prudent course of action for the client on the basis of the needs and strengths with which he or she presents. This phase would necessarily include assessing the client’s readiness to change as suggested by Prochaska and DiClemente’s Transtheoretical Model (e.g., precontemplative) because this would assist in setting appropriate treatment goals (Prochaska, DiClemente, & Norcross, 1992). In addition, community resources are also taken into consideration at this point. Many clients who are sexually addicted will not admit to there being a problem until their lives become unmanageable (Carnes, 1994a)—and only then will they seek treatment. Consequences such as ruined marriages, sexually transmitted diseases, undesired pregnancies, arrests, or court orders are often the impetus that brings clients in for treatment. It is therefore crucial that counselors recognize the addictive nature of sexual activities, accurately assess the effect that these activities are having on clients (as well as significant others), and make it a priority that individuals cease all illegal or self-destructive activities (Schneider, 2000).

During clinical evaluation, the counselor’s knowledge of sexually compulsive behaviors should be broadly based in order to accurately and appropriately diagnose clients. This is particularly necessary to distinguish among those behaviors that can best be categorized and treated as addictions, compulsions, impulse control disorders, and paraphilias. It is therefore important to gather information on the nature, time of onset, duration, frequency, and the progression of the
experienced symptoms (Seligman & Hardenburg, 2000). Gathering a comprehensive sexual history during the initial interview is particularly useful in assessing prognosis and gauging the risks of relapse.

In performing a thorough multimodal and multimethod assessment, counselors are encouraged to use both structured interviews and formal assessment instruments. Based on the diagnostic criteria of Goodman (2001) discussed earlier, the first author of this article has developed an acronym to serve as a structured interview for the purposes of diagnosing sexual addiction. Similar to the success of the CAGE clinical interview that was developed by Ewing and Rouse in 1970 (Ewing, 1984) to assess for the presence of alcoholism, the acronym WASTE Time was created for working with clients presenting with sexual addiction. The designation of this particular acronym seemed appropriate, given the tremendous amount of wasted time that most clients who are sexually addicted admit to the pursuit of their sexual behaviors.

Each of the acronym’s letters corresponds to one or more of the diagnostic criteria for sexual addiction and can be tailored in such a way so as to (a) avoid resistance and denial and (b) fit the clinical setting and individual client.

**W: Withdrawal.** “Have you experienced any withdrawal symptoms when you are unable to engage in sexual activities?” Typical responses may include irritability, anxiety, depression, anger, and/or other negative mood states. Clients may also reveal using other behaviors or chemicals to supplement their addiction to sex.

**A: Adverse consequences.** “Have you experienced any negative or adverse consequences as a result of your sexual behaviors?” Typical responses may include broken relationships, lost career opportunities, financial difficulties, physical injury, and/or psychological trauma. This question can lead to a discussion of the activities and life domains that have been reduced or sacrificed for the addictive disorder.

**S: inability to Stop.** “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 may include multiple attempts at stopping or controlling the addictive behaviors without success, even when faced with the knowledge that continuing poses a physical or psychological problem.

**T: Tolerance or intensity.** “Have you found it necessary to increase the amount or intensity of your sexual behaviors to achieve the same effect?” Typical responses may include movement within levels (e.g., movement from compulsive-like, online sexual encounters coupled with masturbation to real-life encounters with multiple anonymous partners [examples of Level 1 behaviors]) or between levels (movement from Level 1 behaviors to compulsive-like voyeurism or exhibitionism [examples of Level 2 behaviors] or from Level 2 behaviors to compulsive-like stalking and/or rape [examples of Level 3 behaviors]). For a thorough discussion of the three levels of sexual addiction, read works by Carnes (1994b) such as Out of the Shadows.

**E: Escape.** “Do you use sexual activity as an escape from negative mood states, such as stress, anxiety, depression, sadness, loneliness, or anger?” Typical responses may include any negative mood state.
Time (two Time domains):

**Time spent (preparing, engaging, or recovering).** “Have you found yourself spending a lot of time preparing for, engaging in, or recovering from a sexual activity?” Typical responses may include such ritualistic behaviors as cruising all evening in search of a sexual conquest, sexual exercises to increase stamina, or the use of addictive chemicals in preparation for sexual activities.

**Time wasted:** “Have you been spending more time and/or more resources on your sexual activities than you intended?” will elicit such typical responses as hours spent on the Internet, a loss of sleep due to an entire weekend spent on voyeuristic activities, or a lost paycheck spent on sexual activities.

Clinical practice has demonstrated the efficacy of this assessment tool. An affirmative answer to one of the above questions suggests a strong possibility that a sexual addiction is present and indicates the need for further assessment as well as an intervention by a trained counselor. An affirmative answer to two or more of the questions indicates a high probability of sexual addiction, warranting immediate intervention by a trained counselor. Typical interventions include inpatient hospitalization, outpatient counseling, and/or self-help support group attendance.

In addition to structured interviews, several assessment instruments are available to assist in the identification of sexually addictive behaviors. Some examples are the Sexual Addiction Screening Test (Carnes, 1994a), the Sexual Dependency Inventory–Revised (Delmonico, Bubenzer, & West, 1998), the Compulsive Sexual Disorders Interview (Black et al., 1997), and the Sexual Compulsivity Scale (Cooper et al., 2000). Whereas many of these instruments have been developed through clinical practice and examination, some empirical work has been done to demonstrate psychometric stability. For example, Xavier da Silveira, Vieira, Palomo, and Silveira (2000) documented a Cronbach’s alpha of .89 for a Brazilian version of the Sexual Addiction Screening Test. Similarly, Delmonico et al. demonstrated high reliability and validity (both criterion and construct) for the Sexual Dependency Inventory–Revised. Finally, Kalichman and Rompa (2001) have shown high levels of reliability and validity for using the Sexual Compulsivity Scale to assess for sexually addictive behaviors in HIV-positive men and women.

By involving significant others in the screening and assessment phase, the extent of how clients’ actions have affected those with whom they live can be assessed. Schneider (2000) identified “issues of trust, betrayal, anger, decreased intimacy, and loss of self-esteem by the significant other” (p. 274) and suggested that significant others be involved throughout the therapeutic process. Similarly, we have found it helpful to require attendance at community-based support groups for significant others (e.g., Codependents of Sexual Addiction, National Council on Codependence, or S-Anon International Family Groups). Finally, clients should be aware of any legal ramifications of their actions, including limits of confidentiality, as well as be connected to community 12-step support groups such as Sexaholics Anonymous, Sex and Love Addicts Anonymous, Sex Addicts Anonymous, Sexual Compulsives Anonymous, and Sexual Recovery Anonymous in order to address the need for accountability.
Carnes (1994a) identified two primary challenges to the screening and assessment phase. First, the hidden nature of sexual addiction, often minimized or rationalized by both clients and their families, complicates the initial diagnosis. For example, clients may initially present with a financial crisis. Over time, it may be revealed, or become apparent, that the financial crisis is the result of significant money being expended on sexual activities. Therefore, addictions and offender counselors must use continual assessment (Vacc, 1982). This process ensures that a client’s needs and diagnoses are continually reassessed throughout the counseling process, and, thus, sexual addiction is not ruled out prematurely. The second challenge involves those issues that are dramatic or that make an accurate diagnosis ambiguous. For example, if a client has had a recent suicide attempt (which may occur with individuals who are sexually addicted) or is experiencing other significant issues such as alcoholism, gambling, or domestic violence, these presenting issues may cloud the initial diagnosis of sexual addiction. With an awareness of the hidden and interrelated nature of sexual addiction, the counselor will be prepared to make a precise and timely evaluation.

**Treatment Planning**

The treatment planning phase involves a collaborative process in which counselors and clients establish desired treatment outcomes and identify the strategies for achieving these (DHHS, 1998). This planning involves providing feedback to clients and significant others concerning the conclusions that were drawn from the screening and assessment phase. This phase includes both an exploration of the identified maladaptive sexual behaviors and a systems approach to those issues that have an impact on the treatment process. These issues include health concerns, relationships with family and friends, concurrent addictions, employment, education, spirituality, and legal needs (Carnes, 1994a; DHHS, 1998).

Hagedorn (2003) identified several treatment goals that are useful in working with clients who are sexually addicted. These are similar to the treatment goals necessary in working with clients who are addicted to chemical substances. The first is to work with the family unit, especially because many seek counseling as a result of a marital or family crisis (Carnes, 1992, 1994b; Schneider, 2000). Possible treatment goals would be to establish rapport with family and significant others, include people who are sexually involved with the client (i.e., partners of the client), and investigate the impact of family dynamics/roles on the development of the addictive behaviors. Additional treatment goals for the individual who is addicted include (a) education regarding the different types of addiction (chemical and process), (b) education regarding available self-help groups for sexual addiction, (c) addressing client denial of sexual addiction, and (d) processing 12-step assignments related to sexual addiction. Finally, Hagedorn noted the importance of coconstructing treatment plans, assisting clients in setting short-term and long-term goals, and helping clients to evaluate their progress in treatment.
Referral

Through the clinical evaluation and/or treatment planning phases, clients should be made aware of available community resources and support systems in order to make initial progress toward meeting identified needs (DHHS, 1998). For example, if clients are experiencing legal ramifications, contacts for legal aid should be provided. Counselors should also provide information about the availability of local 12-step meetings. In addition, if clients desire spiritual support and counselors are not able to supply this necessary adjunct to counseling, they should provide information about where to obtain spiritual support.

As previously noted, clients who are sexually addicted often seek treatment only after experiencing significant negative consequences. As a result, some clients may be ordered by a court to obtain treatment or encouraged to seek treatment by a concerned family member or friend, or treatment may be required by clients’ place of employment (Seligman & Hardenburg, 2000). Therefore, if clients present for treatment solely as a means of escaping consequences, self-disclosure may be limited, work toward identified treatment goals will often not progress as planned, and issues of transference (particularly anger directed at the counselor) will likely be experienced. Counselors are encouraged to remember that if the client’s progress is stalled or waylaid because of the aforementioned issues, it may be necessary to explore referral to a more appropriate level of care.

Service Coordination

The coordination of service involves case management and client advocacy, creating an agenda for meeting designative treatment goals, and collaborating with community resources and managed care systems (DHHS, 1998). The goal of treatment is to reduce or eliminate maladaptive behaviors, to improve clients’ overall lifestyle, and to reduce the likelihood of relapse (Seligman & Hardenburg, 2000). Therefore, treatment is typically multifaceted and includes group, individual, and family counseling; medication; education; and self-help groups. The process of coordinating service, therefore, involves a collaborative effort among the primary counselor and the referral agency, the legal system, managed care companies, other health care providers, employers, educators, 12-step programs, and clients’ family and friends. Once these connections have been established, the counselor is well prepared to begin the counseling process.

Counseling

DHHS (1998) indicated counseling is a collaborative process that promotes client progress toward coconstructed treatment goals. The competence of counselors is demonstrated by the awareness, knowledge, and ability to appropriately use the various models of addiction counseling as they apply to working with individuals, groups, families, couples, and significant others (DHHS, 1998). In preparing to counsel clients who are sexually addicted, there are several facets to consider. Among these are (a) the most appropriate setting for treatment, (b) the need for multiple modalities of treatment, (c) the choice of the most appro-
ropriate counseling approach, and (d) the use of psychoeducation and psychopharmacology. Finally, there are several challenges that occur during the therapeutic process.

**Setting.** The first consideration when working with individuals who are sexually addicted, independent of the treatment approach used, is to decide the level of care, either inpatient or outpatient, that the individual needs (Myers, 1995). Unless clients pose a significant physical risk to themselves or someone else or have not responded to previous outpatient treatments and/or the need exists to interrupt a repetitively negative cycle, outpatient counseling is the mode of choice.

**Modality.** Next, counselors must decide which modality (individual, couples/family, or group counseling) to implement as a part of a holistic treatment program. Whereas all three modalities are necessary, group counseling is the modality that is recommended most in working with clients who are sexually addicted (Carnes, 1994a). Group counseling breaks the isolation experienced by clients, assists in the acquisition and practice of communication skills, offers models for coping with compulsions through the examples set by other group members, and provides a “reality check” when members’ thoughts and behaviors are confronted or encouraged by the group (Carnes, 1994a; Seligman & Hardenburg, 2000).

Community support groups are a necessary addition to individual and group counseling. Twelve-step programs such as Sexaholics Anonymous, Sex and Love Addicts Anonymous, Sex Addicts Anonymous, Sexual Compulsives Anonymous, and Sexual Recovery Anonymous “offer twenty-four hour support and a comprehensive structure on which to ground one’s life in general, and one’s addictive problems in particular” (Myers, 1995, p. 481). These programs advocate a foundation of self-honesty, acceptance of one’s limitations, and a sense of spirituality and encourage the development of a network of relationships in which the central component is not sexual (Carnes, 1994a).

Before choosing the most appropriate counseling approach, counselors are cautioned not to underestimate the familial, cultural, and experiential backgrounds of their clients in order to assist in the exploration of the origins and dynamics of the addiction (Carnes, 1994a; Seligman & Hardenburg, 2000). For example, within the clients’ cultural context, are women as well as men allowed to openly discuss sexuality and sexual addiction concerns outside the family system? If not, support groups and group counseling may not be appropriate for these clients. The information gathered can facilitate counselor empathy for clients, can assist clients in clarifying their thinking, and can lead to more effective treatment choices.

**Theoretical approaches.** The counseling literature primarily emphasizes two theoretical approaches to working with clients who are sexually addicted. The first, often grouped under the general label of cognitive-behavioral counseling, uses a variety of techniques (Carnes, 1994a; Myers, 1995; Seligman & Hardenburg, 2000; Smith, 1998; Wolfe, 2000). Familiarity with such techniques as the identification of erotic triggers, anxiety reduction, aversion counseling, covert extinction, orgasmic reconditioning, thought stopping, cognitive restructuring, risk recognition, modification of distorted cognitions, and victim empathy are important. Assisting
clients with developing social and assertiveness skills, as well as educating them on such topics as healthy sexuality and relationships, can encourage the individual to participate in appropriate and peer-oriented activities.

Psychodynamic, or insight-oriented counseling, is also widely used in the treatment of sexual addiction (Carnes, 1994a; Seligman & Hardenburg, 2000). This theoretical approach seeks to assist clients in resolving past and current experiences that maintain the addictive behavior. The goal of this approach is to facilitate the improvement of impulse control, interpersonal skills, and self-esteem so clients can work toward mastering more appropriate avenues to sexual gratification (Myers, 1995).

During the therapeutic process, it is important to assist clients in identifying both the overt and covert motivations that determine their behaviors. Their addictive behaviors may provide a sense of self, a feeling of power, and a direction and meaning to their lives (Goodman, 1993). Once these are explored, Carnes (1994a) suggested that it is very important to bring the client’s “ideal scenarios” to light as early in the counseling process as possible. These ideal scenarios are those fantasies and preoccupations that reveal much of clients’ irrational beliefs and impaired cognitions. Cognitive-behavioral and insight-oriented counseling techniques are instrumental in assisting clients in recognizing these patterns and in learning new coping mechanisms.

**Psychoeducation and psychopharmacology.** Part of the counseling process includes a psychoeducational examination and explanation of the addictive process, which may be approached from the perspective developed by Carnes (1994a) known as the Addictive System. This cycle helps to affirm the individuality of clients while using elements of the psychological, medical, and sociocultural models of addiction. This information can be explained to clients in such a way that feedback is elicited from the individual that would reveal important clues to his or her own addictive process.

The use of psychopharmacology is often a necessary adjunct to talk therapy. The use of selective serotonin reuptake inhibitors has been successful in decreasing both fantasies and compulsions in clients who are sexually addicted (Abouesh & Clayton, 1999). Medications such as fluoxetine (Prozac), sertraline (Zoloft), fluvoxamine (Luvox), clomipramine (also effective in treating obsessive-compulsive disorders), lithium, and buspirone have been shown to be effective (Myers, 1995; Seligman & Hardenburg, 2000). It should also be recognized that the administration of these medications will not entirely curb the sexual activities of clients when they experience a powerful internal need (Myers, 1995) but are often an important part of assisting clients in maintaining positive mood states so that counseling is more effective.

**Challenges to the therapeutic process.** Of the several challenges in working with clients who are sexually addicted, perhaps the biggest threat to continued sobriety is clients’ experience of despair (Carnes, 1994a). Because emotional experiences (e.g., anger, sadness, and emotional pain) are part of the human condition, clients should be prepared to work through “slips” in their recovery. A slip might be defined as a temporary lapse into a sexual act that had been a part of the addictive cycle. The dif-
ference between a slip and a full-blown relapse is that the individual recognizes the act and does not continue the behavior and therefore avoids becoming enmeshed in the full addictive cycle. Carnes (1994a) suggested that to prevent such slips, the establishment of a relapse prevention plan is a crucial element of the counseling process. Such a plan would include concrete and practical steps to be accomplished before a slip occurs (prevention), during a slip, and following the slip.

Another challenge to the counseling process is that many clients who are sexually addicted have engaged in particular behaviors that may make them very difficult people with whom to empathize (Seligman & Hardenburg, 2000). The counselor should be comfortable talking about sex using current euphemisms; should be virtually unshockable; and, most important, nonjudgmental (Wolfe, 2000). Although not unique to this client population, sexual advances made toward the counselor must be specifically addressed when working with clients who are sexually addicted (Myers, 1995).

A final fact to bear in mind is that clients who are sexually addicted will often engage in behaviors that to the nonaddicted appear outrageous, repetitive, dangerous, and dramatic (Myers, 1995). Due to the deep-seated characteristics of these self-meditative behaviors, Myers suggested that it is essential that the counselor become more dynamic and directive in the counseling setting, a task more challenging for some counselors than for others.

According to Carnes (1994a), the goal of counseling clients who are sexually addicted is not necessarily total abstinence, as it is in working with chemically addicted clients. Rather, the goal is to establish a life of sobriety and for the individual to approach sex as an element of a loving relationship and a celebration of life. Rather than turning to sex as a means to self-medicate negative emotional states, clients are taught about healthy sexuality, which might include lessons of intimacy, supplying information about “normal” sex, and delineating between degrading and enriching sex. The counselor is encouraged to be well versed in various healthy sexual practices through additional graduate study in human sexuality.

Client, Family, and Community Education

Information regarding the risks associated with addictive sexual behavior, as well as available prevention, treatment, and recovery resources, should be provided to clients, families, significant others, and community groups (DHHS, 1998). This provision of information can be accomplished both through the distribution of literature and professional presentations. Counselors should be proficient in public speaking and be prepared to disseminate information to the general public, which is generally ignorant of the realities of sexual addiction.

Documentation

Just as proper documentation is important in all facets of counseling, accurate records must be maintained. This includes all aspects of the screening and intake process, assessment results, treatment plans, clinical reports, clinical progress notes, discharge summaries, and other client-related data (DHHS, 1998).
Professional and Ethical Responsibilities

It is the obligation of every counselor to adhere to accepted ethical, legal, and behavioral standards of conduct and to seek continuing professional and educational development (DHHS, 1998). Seligman and Hardenburg (2000) offered clear guidelines for the professional in these areas. Ethically, in working with clients who are sexually addicted, counselors must be aware of their own values, biases, and experiences and remain aware of any strong reactions that emerge in their work with such clients. Any self-disclosure on the part of counselors (particularly around sharing feelings resulting from the behaviors of clients) should be done prudently in an effort to prepare clients for how others may react to their behaviors. In addition, counselors need to be aware of the lack of public understanding, the ignorance and distrust of other professionals, and the often outright public disdain for sexual addicts and be ethically prepared to advocate for their clients (Carnes, 1994a). Legally, the connection between counselors and the court system (if there is such a connection) should be fully explained to clients, as should the limits of confidentiality (to include the duty to warn and the duty to report). Behaviorally, counselors should recall that although building rapport and expressions of empathy are important in the counseling relationship, control must be maintained in interactions with these clients. “Clients should be held responsible for their behaviors, and appropriate limits must be set on such client behaviors as splitting, expressions of rage, and relating experiences primarily to shock the counselor” (Carnes, 1994a, p. 112).

Conclusion

Although sexual addiction is not a new phenomenon, it has become a more recognizable disorder, due in part to the media attention regarding the exploits of those in politics, sports, and entertainment. With an estimated 17 to 37 million Americans struggling with this addictive disorder, the counseling profession faces a unique challenge. Unlike clients who are chemically addicted and who must seek out their drug of choice, individuals who are sexually addicted must learn to maintain a lifestyle free of the enticements offered in the sexual images that are prevalent in today’s society. Often they must learn the skills necessary for this lifestyle without the help of a proficient counselor, because most addiction professionals are often not prepared by their graduate education programs to recognize and treat this disorder.

Some of the complicating factors contributing to the lack of professional awareness in this area have been discussed. These include the lack of consensus in the addictions field regarding the appropriate terminology and criteria for this disorder, the lack of understanding of how sexual addiction relates to other addictive and psychiatric disorders, and the importance of using an addiction model with incarcerated individuals. Similarly, most counselors are never exposed to the realities of sexual addiction during their formal graduate educational experiences (Hagedorn, 2003).

One way to ensure comprehensive coverage of the necessary elements for treating clients who are sexually addicted is to adopt the protocols suggested in this ar-
article. Future research should empirically test the effectiveness of these modalities in working with clients who are sexually addicted. The reader is encouraged to remember that the goal of improved treatment protocols is to improve client outcomes. Ultimately, if counselors do not receive the proper training in the treatment of sexual addition, clients, and those affected by their addicted behaviors, will be the ones who are adversely affected.

References


