

## **He's Not Out of the Woods Yet!**

### **Tiger Woods' Path Through Sex Addiction Treatment**

By: Elaine Brady, PhD, LMFT, CSAT  
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Tiger Woods' recent public apology regarding his sexual transgressions brought into the public light, once again, the controversial subject of "sex addiction." Over the last five years, it seems as if not a month can go by that some new celebrity—be it sports figure, actor, preacher, or president—has been caught *in flagrante delicto* and sent off to sex addiction treatment "boot camp." The general public stands by shaking their heads and tsk-tsking in bemused wonder, "What will they come up with next?"

And we, in the psychotherapeutic community, are not far behind them. Debate over the legitimacy of *sex addiction* as a valid mental "illness," over its appropriate designation and, consequently, over an appropriate treatment model for it has been raging for over twenty years now. In the meantime, many of us remain uncertain how to address the issue when clients (and/or their partners) present with fears they might be a "sex addict." We are unsure how to assess the problem and we have no clear treatment path to follow.

#### **What's in a Name?**

Primarily, the name debate has been centered around whether driven sexual behavior should be called sexual *compulsivity*, sexual *impulsivity*, or sexual *addiction*. These terms reflect various conceptualizations of the problem, which are then thought to guide appropriate treatment. For the purposes of this brief article however, which is to present an early diagnostic & treatment model for driven sexual behavior, I would like to propose two concepts: 1) a legitimate use for the term, sexual addiction, within the therapeutic frame while, at the same time, recognizing 2) the need for a multi-modal approach in the treatment of the disorder.

Ironically, the idea of sex addiction has been fully embraced by the psychiatric profession from its earliest beginnings. The forefather of psychiatry, Sigmund Freud, identified masturbation as a *primary addiction* in 1897 (Freud, 1892–1899/1950),<sup>1</sup> and Otto Fenichel (1945) in his classic text, *The Psychoanalytic Theory of Neurosis*, discussed both "sexual addiction" (p. 385) and "love addicts" (p. 382).<sup>2</sup>

The Diagnostic and Statistical Manual of Mental Disorders actually used the term *nonparaphilic sexual addiction* in the DSM-III-R<sup>3</sup> but subsequently pulled it from the DSM-IV,<sup>4</sup> partly due to fears the term

*addiction*, “would add to the stigmatization of people.”<sup>5</sup> However, current APA committee members engaged in the DSM-IV revision have since reflected:

Experience over the past two decades has demonstrated that this decision was a serious mistake. It has resulted in confusion among clinicians regarding the difference between “dependence” in a DSM sense, which is really “addiction,” and “dependence” as a normal physiological adaptation. Addiction is a perfectly acceptable word. The current labeling is not only confusing and misleading, but it contributes to [patient] suffering.<sup>6</sup>

As a result of these deliberations, the current plan for the DSM-V is to create a new category of [guess what] “Addiction and “Non-substance Addictions.”<sup>7</sup> Suggested candidates for inclusion in this category are gambling, internet gaming, eating, shopping, and *sexual activity*. Hopefully, this inclusion will be a positive step towards establishing commonly accepted nomenclature and clear diagnostic criteria for driven sexual behavior.

### **Treatment Approach**

In the meantime, Schneider & Irons have maintained that “in clinical practice, the label matters less than the treatment approach. Whether clinicians refer to their patients as having an ‘addictive’ or a ‘compulsive’ disorder, most have found that these patients benefit from a treatment program which incorporates elements of addiction treatment.”<sup>8</sup>

Kafka agreed that “successful treatment of these conditions commonly requires more than one type of mental health intervention”<sup>9</sup> and, in a review of the literature, Finlayson found, “addiction treatment can halt compulsive sexual behaviors in patients who could not stop when treatment consisted of traditional psychotherapy and/or medications.”<sup>10</sup>

Even Eli Coleman, who historically warned against the dangers of the “addiction model” and 12-step groups, has acknowledged in more recent years that “some patients find these groups extremely helpful,”<sup>11</sup> and that “many patients find the term ‘addiction’ a useful metaphor to describe their problem.”<sup>12</sup>

In fact, many sex addicts (39-45%) have co-morbid alcoholism and drug addiction issues<sup>13,14</sup> which will also require treatment or for which they have already received treatment—possibly making them more receptive to the concept of sex addiction treatment within a 12-Step model.

Moreover, Goodman (2001) asserts that “effective treatment of sexual addiction requires an understanding,

not only of addictions, but also of psychodynamics, family systems theory, group dynamics, and cognitive-behavioral therapy . . . [and] the ability to recognize major mood disorders and psychotic disorders [as well as] a high level of self-awareness and an ability to manage one's own issues and feelings."<sup>15</sup> It appears, then, that effective treatment of sexual addiction may require a rigorous process of differential diagnosis and an eclectic therapeutic model.

### **Diagnosis and Treatment Path for Sex Addiction**

A basic diagnostic model will be utilized to describe the early assessment and treatment of sex addiction: Presentation, Assessment, Differential Diagnosis, and Initial Treatment Plan.

The diagnostic and treatment path begins when a client/s present/s with the direct concern, "am I a sex addict?" This question typically arises as the result of a partner discovering pornography use (or a recurrence of use), affairs, or because of a significant difference in sexual desire within the relationship. When single individuals come in, it is usually the result of some significant financial, legal, relational, and/or medical repercussion of his/her behavior. What then, is the first step in assessing for the possibility of sex addiction?

The first consideration that must be given to this issue is the risk (both in the client/s and in ourselves) of over-pathologizing sexual behavior. We must remain ever vigilant to the possibility that the client/s concerns (and our own evaluations) may be strongly influenced by deeply enculturated attitudes, beliefs, values/morals, and misperceptions regarding normal human sexuality.

As therapists then, we must be aware of our own personal belief systems and be clear as to our professional limitations in regards to working with sexual issues. We must have adequate education and training in both normal and abnormal sexual behavior and be comfortable addressing a wide range of sexual behavior—both in terms of types of behavior and frequency of behavior. We must be ready to seek consultation or to refer out as needed.

When working with an individual or couple presenting driven sex addiction, it is important we evaluate the behavior within the context of its occurrence. For example, an individual might think s/he is suffering from sex addiction when, in reality, s/he is engaged in behavior that is a normal part of sexual development and expression, is a sexual problem but not an addiction, or that is simply in conflict with his/her own values. Couples may be dealing with cross-cultural issues, differing values, or differing levels of sexual desire and not with compulsion or addiction. Undiagnosed and/or unresolved psychiatric, medical issues, or substance abuse issues may also be a factor.

## Diagnostic Criteria

How then, shall we define sex addiction? Driven sexual behavior can be divided into two main types: *paraphilic* and *non-paraphilic*. In the DSM-IV, paraphilias (or unconventional sexual behaviors) are defined as "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other non-consenting persons."<sup>16</sup> The definition goes on to explain, "The behavior, sexual urges, or fantasies cause clinically significant distress in social, occupational, or other important areas of functioning."<sup>17</sup>

Eight paraphilic disorders are currently listed in the DSM-IV: pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, fetishism, transvestic fetishism, frotteurism.<sup>18</sup> Please note, however, that in keeping with the earlier discussion regarding the wide range of normal human sexuality, some behaviors—sado-masochism, for instance—when they are consensual and do not impair life functioning, would not be considered a paraphilia because they do not meet all of the diagnostic criteria.

As previously noted, although the term *nonparaphilic sexual addiction* was utilized in the DSM-III-R, it was subsequently removed from the DSM-IV. The DSM-IV makes reference to *hypersexuality* under the category "Sexual Disorders Not Otherwise Specified" and offers the following examples: distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used; compulsive fixation on an unattainable partner; compulsive masturbation; compulsive love relationships; and, compulsive sexuality in a relationship."<sup>19</sup>

The DSM-V is now expanding on this descriptor and plans to include it (as *hypersexual disorder*) among other *non-substance addictions* in its chapter on substance-related disorders. The committee notes that, "empirical evidence in support of each 'A' Criterion" was drawn from "three primary putative pathophysiological models: sexual desire/arousal dysregulation, sexual addiction, and sexual compulsivity."<sup>20</sup> The current diagnostic criteria purposed are:

### Hypersexual Disorder

A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:

- (1) A great deal of time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.
- (2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).

- (3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events.
- (4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.
- (5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.

C. These sexual fantasies, urges, and behavior are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication).

Specify if: Masturbation, Pornography, Sexual Behavior With Consenting Adults, Cybersex, Telephone Sex, Strip Clubs, or Other.

Progress, then, is being made towards development of the clinical tools needed to guide effective treatment. Fortunately, specialists in the field of sex addiction have been working on appropriate diagnostic tools for years.

### **Diagnostic Tools**

Chief among these researchers has been Dr. Patrick Carnes, a leading expert on sex addiction, who has developed several self-administered tests (available on his website, [sexhelp.com](http://sexhelp.com)). These include, the Sexual Addiction Screening Test (SAST), the Sexual Addiction Risk Assessment Test (SARA), and the Internet Sex Screening Test (ISST). The Sexual Dependency Inventory-Revised (SDI-R), which provides a wealth of information as to the etiology, range & scope of the problem, is available only in consultation with a Certified Sex Addiction Therapist (CSAT).

Kimberly Young, researcher, author, and director of the Center for Internet Addiction Recovery, offers a number of tests/quizzes on her site, [netaddiction.com](http://netaddiction.com). These include the Internet Addiction Test (IAT), the Cybersexual Addiction Quiz (CAQ), and the Partner's Addiction Test. Familiarizing yourself with these tests can give you a better understanding of the various aspects of sex addiction and will aid you in formulating your own clinical evaluation questions or psycho-sexual-social interview.

A thorough psycho-sexual-social interview will guide the clinician in determining: whether or not the problem is *situational* or *recurrent*, the possibility of co-morbid issues, and provide data for a sex addict profile match. Be cautioned however, that individuals falling prey to *Internet sex addiction* may not fit the “traditional” sex addict profile. Whereas one of the strong “markers” for sex addiction is a long history (usual onset in adolescence) of driven sexual behavior, one large study of cybersex addiction found that 65% of those meeting its criteria had no such history.<sup>21</sup> Assessment of this problem, then, may need to be based on self-report and/or the ISST, IAT, and CAQ.

The following sex addiction profile was developed by Dr. Carnes from his research with over a thousand individuals who sought treatment for sexual addiction.<sup>22</sup> Dr. Carnes found four significant “markers” in this patient population: *a childhood history of parental alcoholism/addiction, dysfunctional family environment, trauma, and adult co-morbidity.*

The breakdown of *parental alcoholism/addiction* issues included: alcoholism/addiction (87%); eating disorder (33%); compulsive gambling (7%); 1 or both sex addicts (36%). *Dysfunctional childhood family environments* were described as: having rigid rules (77%), being emotionally disengaged (87%), or as being both rigid & disengaged (67%). *Childhood neglect/abuse* included: emotional neglect/abuse (97%); physical abuse (72%); sexual abuse (81%). Glaringly apparent in these statistics is the high incidence of dysfunctional family environments and childhood trauma, most notably sexual abuse—at 81% as compared to the general male population rate of 0.6%.<sup>23</sup>

Ample evidence has demonstrated that sexually abused children suffer from more psychological symptoms than children who have not been abused<sup>24</sup> and that, as adults, chief among their symptoms are sexual dysfunctions and hyper/hyposexual behavior.<sup>25</sup>

When questioning a patient regarding childhood abuse however, the clinician must remember that individuals with such a history (for several reasons) are notoriously poor reporters of such abuse and many will report their childhoods as “normal.”<sup>26</sup> In addition, male sexual molest/abuse victims, in particular, consistently discount or minimize their abuse and report far less than girls.<sup>27</sup> Studies of non-disclosure by child victims vary widely, with estimates of non-disclosure ranging from 42% to 100% for boys.<sup>28</sup>

Therefore, information regarding childhood neglect/abuse/molest may only surface after trust has been established in the psychotherapeutic relationship. Initially, the clinician may only be able to infer abuse from information gleaned from the psycho-sexual-social interview and from client symptomatology.

For male molest survivors, such symptomatology might include: compulsive sexual behavior, sexually aggressive behavior, multiple sexual partners, fear and sexual avoidance, fetishism and sadomasochism.<sup>29</sup> Compulsive sexual behaviors include frequent masturbation (up to four or five times per day) and sexual activity with men in pornographic bookstores and restrooms.<sup>30</sup> Gender identity and sexual orientation confusion, as well as internalized homophobia have also been noted.<sup>31</sup>

The fourth significant marker in the sex addiction profile is *multiple lifelong co-morbidities* such as mood and anxiety disorders, dissociative disorders, substance abuse, ADHD, PTSD, and impulse control disorders.<sup>32</sup> Carnes has identified several co-existing impulse control disorders, such as eating disorders (38%), compulsive work (28%), compulsive spending (26%), and compulsive gambling (5%).<sup>33</sup>

In addition to these four primary markers, Carnes has also developed twenty Collateral Indicators for sex addiction and incorporated them into the SDI-R. Interested parties can view this list at: [http://www.lpac.ca/Main/Courses\\_01/sex.aspx](http://www.lpac.ca/Main/Courses_01/sex.aspx). The Inventory states that the average sex addict matches at least six of these twenty Collateral Indicators.

Kafka summarizes the literature on the clinical characteristics of patients with what he terms "paraphilia-related disorder:"<sup>34</sup>

- predominately male
- onset in adolescence
- commonly report multiple rather than single hypersexual outlets over their lifetimes
- describe their sexual behavior as obligatory, repetitive, and stereotyped at times
- more likely to report periods of persistently heightened sexual behaviors leading to orgasm, compared to the general population
- may come to prefer unconventional sexual activities to sex with a partner
- sexual behavior is time consuming, often occupying several hours per day
- sexual behavior may wax and wane, but more likely to occur/intensify during periods of stress
- sexual behavior may be either ego-syntonic or ego-dystonic

He also found that compulsive masturbation was the most common paraphilia-related disorder (70%) and that this was the most prevalent sexual outlet over the course of a lifetime regardless of marital status.<sup>35</sup> Further, he found *severe sexual desire incompatibility* in 12% of his sample, with both male and female "sex addicts" describing periods of wanting or demanding near daily sex (or more), while the affected partner reported feelings of being sexually exploited, demeaned, and/or anger.<sup>36</sup>

Carnes found that 33% of sex addicts suffer from sexual aversion-desire disorder (DSM-IV 302.797) or *sexual anorexia*, as he terms it, while a significant number (72%) report having symptoms of this disorder- often experiencing a binge-purge pattern of sexual acting-out/acting-in behaviors.<sup>37</sup>

As previously noted, the co-morbid and sexual histories of sex addicts typically reflect the effects of their childhood neglect/abuse. This holds true of their destructive relationship patterns as well, in terms of clear symptoms of adult attachment disorder.<sup>38</sup> Their patterns reveal symptoms of either anxious-preoccupied, dismissive-avoidant and fearful-avoidant or anxious/ambivalent attachment: difficulties forming and maintaining relationships, sequential and/or overlapping relationships, unhealthy/abusive relationships, or significant isolation.<sup>39</sup>

Given the level of denial present in all addictive processes and the high rate of dissociative disorders present in this particular population, *collaboration* with other significant parties may be an essential part of the assessment process. Such collaborations might include: the spouse/partner, extended family members, a parole office, general practitioner (for history of genital injury, STD's, hepatitis, HIV/AIDS, unplanned pregnancies, abortions, etc.), or a lawyer. If working with a couple, the same interview should be given to the partner, as they have been found to share almost identical childhood histories and co-morbidity issues as the addicts themselves<sup>40</sup> and their profile will enhance the larger diagnostic picture.

### **Differential Diagnosis**

The psycho-sexual-social interview may also indicate the presence of medical conditions and/or psychiatric disorders (e.g. Schizophrenia and Delusional/Erotomania Disorder) which may be causing the compulsive sexual behavior or be co-morbid with it. General medical conditions, which may be associated with problematic hypersexuality, include a wide range of neurological conditions, endocrine conditions, and medication side-effects.<sup>41</sup> In the presence of *any* reported medical condition, it is wise to inquire if the patient has discussed the presenting problem with the appropriate attending physician. If no recent physical or psychiatric exam has been conducted a referral for either or both may be necessary. Reevaluation of the presenting problem can be made after resolution or stabilization of any identified medical conditions.

While all personality disorders (Axis II) may be associated with interpersonal and sexual difficulties, those grouped in Cluster B are most likely to be associated with hypersexual behavior (e.g. Antisocial, Borderline, Histrionic, and Narcissistic).<sup>42</sup> Even with clear and distinct criteria for problematic hypersexuality however, the accurate differentiation of sex addiction from a personality disorder will require considerable knowledge, training, and clinical experience.

There are also a number of other conditions that are known to occur concurrently with problematic sexual hyperactivity:<sup>43</sup>

- . Adjustment Disorder
- . Attention Disorders: ADD/ADHD
- . Depressive (Spectrum) Disorder
- . Dissociative Disorder
- . Impulse-Control Disorder/Intermittent Explosive Disorder
- . Obsessive-Compulsive Disorder
- . Paraphilia(s)
- . Posttraumatic Stress Disorder
- . Process Addictions (e.g., eating, gambling, working, spending, risk taking)

Please note that these disorders do not override an independent diagnosis of problematic hypersexuality, and they will probably require concurrent treatment to resolve. The general convention in the DSM-IV is to allow multiple diagnoses to be assigned for those presentations that meet criteria for more than one DSM-IV disorder.<sup>44</sup>

Sexual disinhibition and/or hypersexuality has been associated with many substances of abuse<sup>45</sup> and a significant number (39-45%) of sex addicts report co-occurring chemical dependency.<sup>46</sup> A period of complete abstinence (30 days) will be necessary to determine if the presenting problem persists. Caution should be exercised during this period however, as medical monitoring of the detox may be necessary. Post-abstinence evaluation should also include assessment for sexual anorexia (available at [sexhelp.com](http://sexhelp.com)), as the patient may have been self-medicating to compensate for this problem.

### **Evaluating Level of Care**

An essential component of any clinical evaluation is that of determining level of care. Issues indicating the need for inpatient treatment of sex addiction would include: suicidality, significant mental illness, risk of harm to self or other, prior failure at outpatient level or continuation of high-risk, life-threatening sexual practices. In the absence of these issues, outpatient treatment can proceed. Favorable prognosis is warranted when there is a significant commitment to therapy, family support, and prior periods of abstinence from self-destructive sexual behavior.<sup>47</sup>

### **Initial Treatment**

Recovery from sexual addiction is in some ways more analogous to recovery from eating disorders than to recovery from substance use disorders. Unlike chemical dependency treatment, whose primary goal is abstinence from use of all psychoactive substances, the therapeutic goal in addictive sexual disorders is abstinence only from compulsive, self-destructive, and self-defeating sexual behaviors. Development of healthy sexuality is the primary goal, which is usually achieved only through commitment to a program of continued recovery and therapy.

Initial intervention and treatment is focused on helping the client stop acting-out behavior, breaking through denial, increasing support systems, and teaching new coping skills. Stopping acting-out behavior may involve safety contracts, the limiting of financial resources, 12-Step participation, computer blocks/filters, and establishment of an "accountability partner" (someone the client can call if at risk of acting-out).

Breaking through denial might involve: having the client take one or more of the screening tests; making a timeline of relationship/sexual acting-out to clarify cycles and patterns; making a thorough list of costs and consequences; listing his/her "10 Worst Moments;" and/or working out of "Facing the Shadow: Starting Sexual & Relationship Recovery."<sup>48</sup> An end goal of this work is for the client to make a full disclosure to the therapist of all forms of sexual acting out historically engaged in.

Increasing support systems may include concurrent 12-Step meetings, group therapy, reengagement (or more intimate engagement with), trusted friends and family, and/or an outpatient chemical dependency or mental health facility.

Teaching new coping skills might include emotional regulation, relaxation training, stress management tools, communication/conflict resolution skills, and assertiveness training.

In general, the more concrete and directive treatment modalities (behavior modification, psychiatric pharmacotherapy, cognitive-behavioral therapy) tend to be more prominent during the earlier phases of recovery, while the more exploratory, interpersonal, and existential modalities (psychodynamic psychotherapy and spiritual regeneration) tend to be more prominent during the middle and later phases of recovery.<sup>49</sup>

### **Integrating 12-Step Programs Into Treatment**

Schneider & Irons, in their review of the literature, noted that most clinicians have found that sexually compulsive patients benefit from a treatment program that incorporates elements of addiction treatment.<sup>50</sup>

Integrating 12-Step program participation into the psychotherapeutic work can give clients the daily support they need as they attempt to replace their previous primary coping strategy (sex addiction) with healthier

ones. Ongoing attendance can support the therapeutic process, aid in building life skills, and provide a framework for continued lifestyle changes. Parker & Guest provide guidelines for integrating 12-Step programs into psychotherapy and sex addiction treatment and describe the essence of the twelve steps:

Steps 1-3 address the addicted person's lack of ability to control the behavior alone and his/her need to begin recovery. Steps 4-9 focus on taking responsibility for one's actions and personality characteristics, and beginning the process of change. Steps 10-12 concentrate on maintaining and continuing recovery.<sup>51</sup>

In summary, it has been asserted that "effective treatment of sexual addiction requires an understanding, not only of addictions, but also of psychodynamics, family systems theory, group dynamics, and cognitive-behavioral therapy . . . [and] the ability to recognize major mood disorders and psychotic disorders [as well as] a high level of self-awareness and an ability to manage one's own issues and feelings."<sup>52</sup> This article has attempted to provide the clinician with a better understanding of sexual addiction and to offer a model for the early diagnosis & treatment of this issue.

© Elaine Brady, MFT, PhD (MFT18214) 4320 Stevens Creek Blvd, Ste 220, San Jose, CA 95129 408-260-9305

Citations and resources are available through the author at [docelaine@msn.com](mailto:docelaine@msn.com).

*Dr. Brady has over twenty-five years of experience working with substance abuse issues. She is a Certified Addiction Specialist as well as a Certified Sex Addiction Therapist. Dr. Brady teaches at Alliant International Institute, provides consultation and training to treatment centers throughout the Bay Area, and offers individual, couples, and group counseling through her San Jose office. She can be reached at: [elainebrady.com](http://elainebrady.com)*

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- <sup>51</sup> Parker, J. & D. Guest, "Integration of Psychotherapy and 12-Step Programs in Sexual Addiction Treatment," in *Clinical Management of Sex Addiction*. 2002, Brunner-Routledge, NY:NY, p 117.
- <sup>52</sup> Goodman (2001), p 14.