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ASSESSMENT AND TREATMENT OF COMPULSIVE SEX/LOVE BEHAVIOR

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ABSTRACT: Sex-love compulsivity or "addiction" involves most of the same issues as other addictive or compulsive behavior. Reasons for the increase in attention to this problem are suggested, and assessment criteria and procedures, guidelines for treatment, and case examples are provided.

> . . . too much frequency of embraces dulls the sight, decays the memory, induces gout, palsies, enervates and renders effeminate the whole body and shortens life.
>
> —John Evelyn

> Love is to man a thing apart . . . 'tis a woman's whole existence.
>
> —John Byron

During the past two decades, tremendous interest has been generated among professionals and in the lay press in the topic of sex and love "addiction." These related topics have been the focus of several popular books, including Robin Norwood's (1986) *Women Who Love Too Much,* Charlotte Davis Kasl's (1989) *Women, Sex, and Addiction,* Patrick Carnes' (1983) *Understanding Sexual Addiction,* and Penelope Russianoff's (1982) *Why Do I Think I Am Nothing Without a Man?* Belief in sex/love addiction and the desire to do something about it has spawned numerous 12-step programs, including Sexaholics Anonymous, Sex and Love Addicts Anonymous, Homosexuals Anonymous, Codependents Anonymous, and Codependents of Sexual Addicts. Although there is little data to substantiate claims that these problems are reaching epidemic proportions, many experts estimate that at

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least one person in 20 experiences dysfunctional levels of compulsive sex/love behavior in one form or other. Psychologist Al Cooper (1998), Clinical Director of the San Jose, California Marital and Sexuality Centre, estimates that between 7 and 10 percent of the U.S. population is afflicted with some form of sexually compulsive behavior.

Many cultural forces have fomented people's preoccupation with sex. These include pervasiveness of sexual stimuli in television, films and advertising; the increasing number of peep shows, sex clubs, and erotica tape sections in video stores; and the wide availability on the Internet of Web sites, chat rooms, and personal ads devoted to sex and erotica. Ironically—despite the dampening effects of AIDS—"easy sex" has become easier than ever. What about "addiction" to love relationships, belief in and concern about which has also increased? Why the increase? Blaming the media would be handy, but it raises the chicken-or-the-egg question. Nevertheless, the proliferation of everything from teen/pre-teen magazines instructing girls in how to surely evaluate "boyfriend potential" (as they MUST) to the tawdry talk shows that model ill-conceived, impulsive, disloyal, and short-lived love relationships, reflect and could influence standards in our culture about love and the "need" for it. As well, our culture's vast increase in shorter-term relationships (and of breakups and divorce) and "serial monogamy" may well intensify some people's focus on love relationships.

While the terms sex and love "addiction" are most widely used, my own preference is for the term "compulsive sex/love behavior." For one thing, it avoids the risks of the "addict" label, which tends to lump its etiology and treatment into the same bag as substance abuse when in fact, as many have argued, it may fit better into the treatment models for the broad-spectrum obsessive-compulsive disorders. For another, it is a more comprehensive term because it includes not just compulsive sex or relationship behavior, but both. In this article, I define compulsive sex/love behavior as existing when people do not and seem unable to curb, modify or control their sexual or relationship behavior, even when they are aware of actual or potential self-defeating social, medical, and/or financial consequences.

CLINICAL EXAMPLES

The following are a sampling of cases I have treated or supervised in recent years at the outpatient clinic of the Albert Ellis Institute.

- 41-year-old Larry, happily married with a 3-year-old child, was recently discovered by his wife to have spent hundreds of dollars a month after work going to peep shows and clubs with "lapdancers."
- Herb spent upward of 25 hours a week in chat rooms and on porn Web sites, and in downloading, cataloging, and masturbating to bondage and discipline images. He would often do this throughout the weekends and into the wee hours of the morning on work days. This negatively affected his performance at work and kept him from developing his social life.
- 36-year-old Lorraine, when she had no evening plans, got "telephonitis" and called tried and untrue boyfriends whom she often wound up sleeping with to stave off her feeling of emptiness and terror of being alone.
- John cruised public toilets off the expressway three or four times a week for an anonymous "quickie" with another male.
- Carlos was fixated on a woman whose apartment windows faced his, and although he had never dared to approach her, he stalked her for hours and was convinced there was no point in even dating other women.
- For most of her marriage, Mona had a succession of lovers to assuage her boredom and her need to be assured of her continued attractiveness to men. Although she had never been "caught," she was filled with anxiety that one day she would be and that her marriage would be destroyed.

PSYCHOLOGICAL DISORDER OR RIGHT-WING BACKLASH? (AND OTHER DIAGNOSTIC CONUNDRUMS)

Some argue that recent identification of the addictive quality of some people's sexual behavior heralds an important therapeutic development. Others, such as Levine and Troiden (1988), argue that the concept of sexual addiction invents a disease based on people's sexual choices and actions, and thus "constitute(s) an attempt to repathologize forms of erotic behavior that became acceptable in the 1960's and 1970's" (p. 349). Others fear that religious fundamentalists will use the term "sex addiction" as an opportunity for a new witch hunt for those who deviate from heterosexual monogamy.

Further complicating the issue is the considerable disagreement among professionals as to the appropriate way to formulate and treat the problematic behavior. Carnes (1991) viewed sexual addiction as "a pathological relationship with a mood altering experience." Earle,

Earle, and Osborn (1991) saw it as something that comes from unresolved childhood issues, while Goodman (1992) suggested that a strong element in such behavior was a neurobiological predisposition to addiction. Others saw it as a problem of impulsivity or as a variant of OCD amenable to cognitive-behavioral treatment (Coleman, 1990, 1992).

This confusion was reflected in the DSM-IV (American Psychiatric Association, 1994). In it, nonparaphiliac compulsive sexual behaviors were listed under the category of "Sexual Disorders Not Otherwise Specified," and their central feature was "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" (p. 538). Of paraphiliac behaviors such as exhibitionism, fetishism, pedophilia, and voyeurism, that is, unusual and personally or socially unacceptable stimuli required for arousal or orgasm (Money, 1986), the DSM-IV held that the essential feature of these behaviors, urges, or fantasies was that they "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 1994, pp. 522–523). Such consequences (of either type of disorder) might include losing one's job, neglecting work or friends because of hours spent on erotic Web sites, being beaten, or contracting STDs. As is often the case with addictive behaviors related to substance abuse, other concomitants of sex/love compulsivity are denial, repeated efforts to discontinue or decrease the activity, and hours spent in the activity or fantasizing about it (Cooper, 1998; Irons & Schneider, 1997).

Whatever the conceptualization, many gray areas—some of which quite clearly interface with cultural values and personal preferences—remain. Is it "pathological," for example, to:

- Insist on having mainly one sexual routine, such as 10 seconds on the left nipple, five on the right, then four minutes of wompety womp in the missionary position when your partner rarely orgasms and is dissatisfied with this routine? What if the partner *is* satisfied or does not care?
- Masturbate almost exclusively to certain erotic films or magazines as it is much less of a "hassle" than partner sex?
- Have sex only after the 11 o'clock news?
- Have sex 10 times more often than the average person your age and your gender?
- Have had dozens of recreational sex encounters in the 1960's when the "sex revolution" was on and AIDS had not surfaced?

- Have them now, using safe sex procedures?
- Have them now, not using safe sex procedures?
- Remain with a psychologically abusive partner because you "need" the person and can't imagine life without him or her?

ASSESSMENT

As with other issues presented in therapy, a comprehensive assessment would best be made in order to understand the behavior in the larger context of the person's life. The first part of the assessment is directed at determining the extent to which the presenting complaint is potentially or actually self- and/or other-defeating. Questions can include those suggested by Coleman (1992). I have taken the liberty of expanding the questions (see brackets) to include not just sexual compulsivity, but love/relationship compulsivity:

- Do you, or others who know you, find that you are overly preoccupied or obsessed with sexual activity [love relationships]?
- Do you ever find yourself compelled to engage in sexual [love relationship] activity in response to stress, anxiety, or depression?
- Have serious problems developed as a result of your sexual [or love relationship] behavior, such as job or relationship loss, contracting or spreading sexually transmitted diseases or other illness, experiencing or causing injuries, or getting charged with sexual offenses?
- Do you feel guilty and ashamed about some of your sexual [or love relationship] behaviors?
- Do you fantasize or engage in any unusual or what some would consider "deviant" sexual behavior [love fantasies]?
- Do you find yourself constantly searching or "scanning" the environment for a potential sexual [or love] partner?
- Do you ever find yourself sexually [or romantically] obsessed with someone who is not interested in you or does not even know you?
- Do you think your pattern of masturbation is excessive, driven, or dangerous?
- Have you had numerous love [or sex] relationships that were short-lived, intense, and unfulfilling?
- Do you feel a constant need for sex or expressions of love in your sexual [or love] relationships?

This portion of the assessment preferably should also include the history of the present complaint, any treatment already received, and current therapy goals.

A comprehensive assessment of the client, similar to that undertaken in dealing with other sex/love problems, should then be undertaken. Preferably it would include the following (Wolfe, 1993):

- Existence of a "problem about the problem." What dysfunctional emotions and behaviors have resulted in the client (or his or her significant other) as a result of the compulsive sex/love behavior?
- Presence of other sexual dysfunctions, such as erectile or orgasmic difficulties
- Biological factors, such as medical conditions, injury, substance abuse
- Early sexual/family experiences, including family attitudes about sexuality, sex education, sexual or physical abuse, masturbation, body image, and love relationships
- Relationship problems in current and past relationships, including family of origin
- Presence of significant emotional problems, including depression, anxiety, impulsivity, compulsivity, personality disorder(s), and ineffective handling of stress

MAJOR AREAS FOR INTERVENTION

Whatever the particulars of the presenting problem, three key issues generally need to be focused on in therapy. They are similar to those involved in the treatment of other addictive and compulsive disorders:

1. NEED for ego gratification or affirmation
2. Low frustration tolerance/impulsivity—the NEED to escape or avoid uncomfortable affect, whether it is negative and dysfunctional or negative and functional (Ellis & Velten, 1998; Robb, forthcoming). Less likely, but also possible as an expression of low frustration tolerance/impulsivity, is the NEED to enhance positive (functional or dysfunctional) feelings. The affective states in question can include anxiety, depression, loneliness, boredom, horniness, frustration, sadness, anger, excitement, feelings of superiority, happiness, and so forth.
3. Short-range hedonism

Need for Ego Gratification or Affirmation. The people who are likely to pursue a series of sex/love affairs are those who tend to question and obsess about—if no one is lusting after or romancing them—their attractiveness, sexiness, or other desirability. These questioners can include anyone from the typically socialized woman who believes that

she is nothing without a man, to the man whose self-worth increases as a function of the number of conquests he can make. Typical Irrational Beliefs are: "To be worthwhile, I must have a man who desires me; without one, I am *a loser* who can *never* be happy and fulfilled"; "I've got a wife, and a chick on the side—women are coming out of the woodwork! I'm *cool—a real stud.*"

Low Frustration Tolerance/Impulsivity. Whether it is the depressed person recently out of a relationship or someone "highly-sexed" and obsessed with sexual stimuli, almost invariably a virulent case of "I-can't-stand-it-itis" drives the person to compulsively seek out others for sexual and affectional contact. Key Irrational Beliefs may include: "I'm so horny I *can't stand* it for another minute; I HAVE TO get to my favorite (massage parlor) (sex club) (Internet site) (cruising area) ([boy] [girl] friend)"; "I'm so lonely and bored *I'll die* if I don't have some human contact; I NEED to have someone to make me feel good."

Short-Range Hedonism. This issue is particularly operative when a person engages in some sex/love behavior that potentially incurs heavy personal, social, or health risks. Examples include having unprotected sex with an unknown partner or having an affair that seriously jeopardizes one's primary sex/love relationship, job, or even physical safety. Among the rationalizations a short-range hedonist might voice and that are based on Irrational Beliefs are these: "S/he'll never find out; my cover is perfect"; "He doesn't look like someone who could possibly have AIDS"; or "I'd have to be crazy to turn down a chance with such a knockout when she all but threw herself at me!"

THERAPIST CAVEATS

In many cases, the window of opportunity may be small for therapeutic engagement in working with clients who show sex/love compulsions. Shame about their societally disapproved and self-defeating behavior, and ambivalence about giving up an anxiety-relieving and often highly pleasurable behavior, are several factors that make the establishing of sound rapport and early therapeutic engagement especially important. In this, clients with sex/love compulsions can be similar to many clients presenting other compulsive or addictive problems. It is critical that the therapist be at ease in talking about sex in the popular vernacular, virtually unshockable, and above all, nonjudgmen-

tal. In addition, therapists would better be skilled and experienced in conducting a multimodal clinical assessment (including biological factors and personality disorders) and in treating sexual dysfunctions and addictive/compulsive behaviors.

CASE EXAMPLE

At our first session, Lorraine, a successful 36-year-old real estate broker, listed the main problems she wished to overcome as "obsessing, codependency, low self-esteem, and bad relationships with men." She had been in therapy on and off since the age of 18 and had been attending CODA (Codependents Anonymous) groups for the past two years, as well as AA to maintain the six and a half years of sobriety she had achieved after 10 years of problem drinking. Following the breakup of a relationship, she had been taking Prozac and Buspar for the past year and a half. At intake Lorraine reported that she was feeling less depressed and anxious than previously had been true; however, especially after so many years of therapy, she felt hopeless about herself and her ability to ever have a successful sex/love relationship.

Lorraine described her mother as someone she found very difficult to trust, a critical, angry person who was sometimes violent to Lorraine's sisters, but who viewed Lorraine as the apple of her eye and leaned on her emotionally. Her father, whom she described as having had "good values but not very emotionally expressive," had died after a 10 year illness when Lorraine was 13 years old.

Lorraine had highly significant scores on the borderline, dysthymic, histrionic, and self-defeating scales of the Millon Clinical Multiaxial Inventory (Millon, 1994). Therefore, psychometric results were congruent with the lengthy history of disturbance she reported and were suggestive of a diagnosis in the spectrum of personality disorders.

The first two therapy sessions were spent in teaching Lorraine the ABCD's of Rational Emotive Behavior Therapy (REBT) as they applied to her specific problems. For example, the first ABC sequence she learned to formulate and interrupt had as Consequences (C1) the anxiety and depression she experienced when she had no plans for the evening (Activating Event, A1). In this ABC, the Irrational Beliefs (IB1) appeared largely to do with self-rating. Then, based on low frustration tolerance Irrational Beliefs (IB2), Lorraine "treated" her anxiety and depression by compulsively telephoning until she found someone (often an tried-and-untrue boyfriend) to hook up with. This set of behaviors, designed to mitigate the depression and anxiety, comprised C2. Related to C2 in that second ABC sequence, Lorraine would almost inevitably wind up having sex with the exes. Then, in a third ABC sequence after she had had sex and found herself once again in an unsatisfying situation (A3) (being treated dismissively by the men) that highlighted her loneliness and feelings of futility, she would get into fights (C3) with the men for not

treating her the way she needed them to (IB3) for her to feel worthwhile. The latter was a variation on the theme in the first ABC sequence.

Lorraine would also hate herself (IB4) and feel despair (C4) for having put herself again through the whole ordeal (A4). Seeing the seemingly endless repetitions of her self-defeating behavior reminded Lorraine of her choices in the past. Those choices included having had three abortions in the last four and a half years (A5), as she "should not" have done (IB5), and now reminded of which, she felt intense guilt, despair, and anxiety (C5). The latter emotions were new Activating Events (A6) that that became another focus of Lorraine's low frustration tolerance philosophy (IB6) and self-defeating attempts to "treat" them (C6) by calling the old boyfriends.

Another key objective in therapy with Lorraine was helping her deal more constructively with her anger and hurt when criticized at work. Along with cognitive methods, an important therapy technique to meet that objective was her role-playing more effective ways of expressing herself as alternatives to her usual pattern of rage or withdrawal.

During our third session, Lorraine and I developed the following three-month goal sheet. It combined cognitive, emotive, and behavioral tasks all geared toward her goals of reducing some of her impulsivity and helping her establish a wider array of interests and friendships so as to reduce her dependency on males.

THREE-MONTH GOALS

- Behaviors I wish to increase:
  - ↑ Staying home three 4-hour blocks of time each week and nurturing self
  - ↑ Sign up for a photography course
  - ↑ Cultivate one or more female friendships or join a women's group (to reduce dependency on men and to have corrective emotional experiences with women)
  - ↑ Use progressive relaxation when feeling anxious
- Behaviors I wish to decrease:
  - ↓ Food bingeing when lonely
  - ↓ Compulsively going out to avoid being alone
  - ↓ Pursuing men who don't treat me well or who do not want to be close to me
  - ↓ Attacking or withdrawing when criticized or rejected
- Feelings I wish to increase:
  - ↑ Self-acceptance, calm
- Feelings I wish to decrease:
  - ↓ Anxiety when alone or when a partner isn't "connecting"
  - ↓ Rage when a partner treats me poorly or disappoints me
  - ↓ Feeling down about myself
- Sensations I wish to increase:
  - ↑ Pleasure in my own body independent of a man's touching it
  - ↑ My old pleasure in music, art, nature

- Sensations I wish to decrease:
  - ↓ Painful neck tension when anxious
  - ↓ Feelings of pain/emptiness in my chest when alone
- Thoughts I wish to increase:
  - ↑ I am a worthwhile human being, capable of happiness even if I never have the sex-love relationship I want
  - ↑ Loving friendships with women are not paltry substitutes
  - ↑ Just because my body and personality are imperfect, doesn't mean I'm worthless
- Thoughts I wish to decrease:
  - ↓ If I'm not in a sex/love relationship, I'm abnormal, no good, a loser
  - ↓ Being alone is the most terrifying thing in the world—it's awful and intolerable
  - ↓ I must get my nonresponsive partner to connect with me—I can't bear it if he doesn't and must do everything in my power to make him change

Lorraine had approximately five months of individual therapy. Although she initially showed considerable low frustration tolerance both in doing written self-help forms and in implementing more adaptive ways of dealing with her distress, her sense of efficacy when she did manage to spend a night alone encouraged greater compliance in the subsequent weeks. We did assertiveness role-plays regularly, both on situations from her outside life and also on any in-session interactions in which she felt angry, pressured, or in any way upset with me. She reported being able to much more effectively handle criticisms and resolve disagreements both in her work and social interactions. Although she was not dating anyone when we terminated therapy, she was filling her time quite enjoyably. In addition, with the exception of one lapse, Lorraine had resisted calling an old lover when lonely. She was encouraged to remain on her Prozac to help with her impulsivity and depression. In consultation with her psychopharmacologist, she tapered off Buspar.

SUMMARY

As many experts in the field have pointed out (Ellis, 1995; Goodman, 1992), a significant majority of those with addictive and compulsive tendencies are particularly difficult to work with. This is so given (1) their strong biological tendencies to have many thinking, feeling, and behavioral deficiencies; (2) their long history of being severely disturbed; (3) their history of poor social relationships, including with therapists; (4) their innate and acquired inadequate frustration tolerance that interferes with the very hard work of therapy; (5) their old friendships with other addicts; (6) their damning of themselves for their personality disorders, addictions, and other failings; and (7) their deep-seated feelings of worthlessness and hopelessness.

According to Goodman (1992), sexual addiction is resolved when people believe they can have and do have the resources to achieve sufficient gratifications from activities inconsistent with compulsive sex. The resolution of love relationship compulsivity would, I believe, be similar. From an REBT perspective, freedom from compulsivity involves a philosophical shift of the sort REBT calls "getting better" and AA calls "sobriety" (as opposed to being dry) (Velten, 1996). The therapist's part of this cognitive-emotive-behavioral shift involves teaching and encouraging clients to dispute Irrational Beliefs regarding ego gratification/affirmation, frustration, and hedonism, and to replace such IB's with more adaptive Rational Beliefs. Doing this, with congruent behavioral homework, proves to be very helpful in decreasing clients' anxiety, frustration intolerance, and impulsivity, and in increasing their self-acceptance. The approach I described above—involving multiple interventions in the psychological, interpersonal, and biological domains—seems to provide a useful vehicle to help clients suffering from sex/love compulsivity problems achieve more control and satisfaction in their lives. This approach does not conflict with interventions at the biological level; medication, improved self-care, and relaxation procedures are often key factors in helping clients decrease anxiety and improve their overall organismic brightness. On the behavioral level, social skills training, anger management, assertiveness training, and contingency management techniques help facilitate the development of more adaptive social relationships.

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