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Shame Reduction, Affect Regulation, and Sexual Boundary Development: Essential Building Blocks of Sexual Addiction Treatment

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Sexual addiction is an intimacy disorder that is rooted in impaired early attachment experiences. This impaired bonding causes the developing self to be shrouded in shame. Primary needs and desires become contemptuous to the individual. Affect regulation also is damaged because of negative bonding experiences. This further impairs the capacity to master feelings and successfully guide the process of need fulfillment. Sexual addiction is a compulsive cycle that attempts to compensate, soothe, and regulate the internal struggle. The cycle, in turn, creates more shame and dysregulation of affect. Strategies to reduce shame, regulate affect, and create sexual boundaries necessary for successful treatment of sexual addiction are outlined.

Sexual addiction can best be conceptualized as an intimacy disorder (Schwartz & Masters, 1994) manifested as a compulsive cycle of preoccupation, ritualization, sexual behavior (or anorexia—excessive control over sexual behavior), and despair (Carnes, 1983). Central to the disorder, is the inability of the individual to adequately bond and attach in intimate relationships. The origin of disorder is rooted in early developmental attachment failure with primary caregivers (Carnes, 1983, 1991; Schwartz, 1996). Sexual addiction becomes a way to compensate for this early attachment failure. The ultimate treatment goal for sex addicts is to master the experience of bonding and attaching in enduring and trusting intimate connections with others.

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The treatment challenge for clinicians is to find specific strategies to assist these individuals to reach this objective.

Three key barriers prevent addicts from breaking the compulsive cycle and establishing successful intimacy: shame, affect dysregulation, and an inability to maintain adequate sexual boundaries. Shame is a feeling that alienates the self from the self and others (Kaufman, 1980); as illustrated by client in Figure 1. It is experienced as self-contempt, feelings of inadequacy, and painful disapproval of the self. It originates from inadequate early developmental caretaking and is reproduced with painful intensity by the compulsive cycle of sexual addiction. Many feelings, self-appraisals, and life experiences are filtered through the lens of shame, further alienating the individual from himself and others. Intimate connections are lost, and further reliance on the addiction occurs. Strategies to reduce shame and alter the subsequent belief system are paramount to sexual addiction treatment.

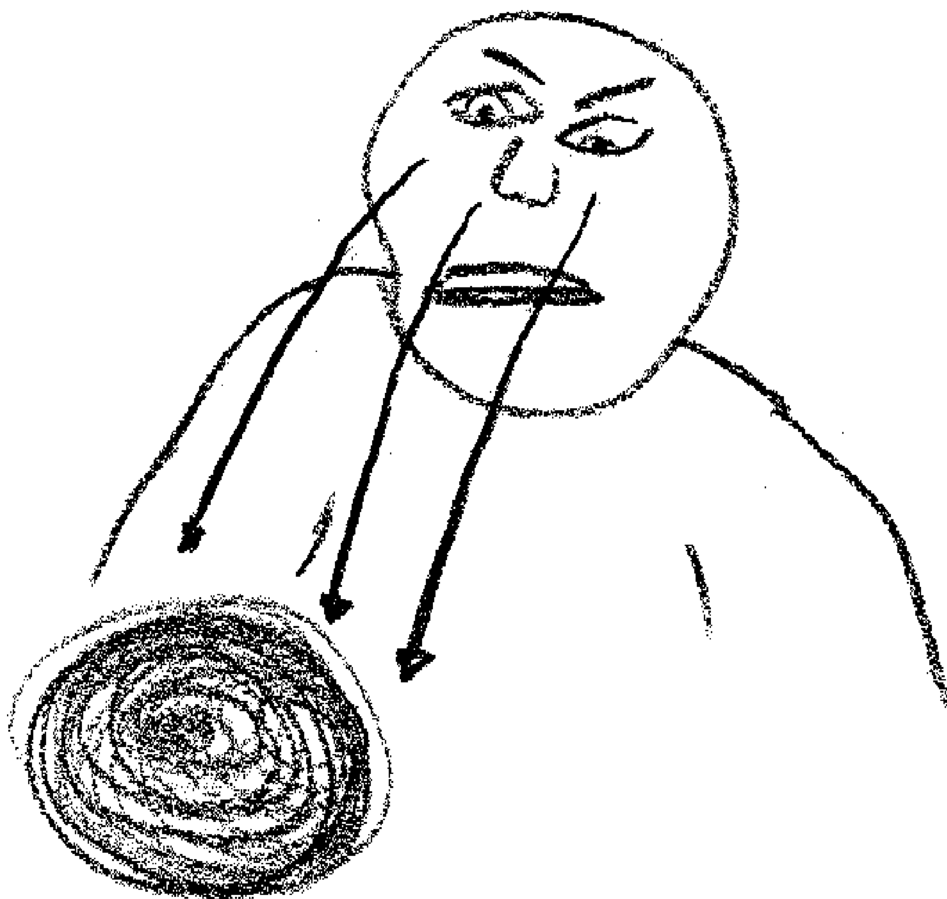

FIGURE 1. A depiction of shame by a sexually addicted client.

The ability to successfully master affective states (i.e., feelings, moods, impulses, cravings) to achieve intimacy and other successful life experiences, can be traced to "good enough" parenting (Winnicott, 1965). When there is a failure in early developmental caretaking, the child is unable to soothe feelings of loneliness, sadness, anger, and fear. Strong affects that the individual is unable to regulate (affect dysregulation), may be linked to rituals around the natural function of sexuality (Schwartz, 1996). Here, pleasure and orgasm is used to soothe and comfort states of internal distress. Sexual feelings merge with shame, sadness, anger, and loneliness, which then become triggers for the addictive cycle. The addiction causes further shame and affect dysregulation. In turn, the individual uses the addictive system again to soothe and reproduces a new layer of shame and dysregulation. Strategies to assist individuals to find alternate ways to discharge painful feelings and regulate affect are crucial to treatment.

One of the hallmarks of sexual addiction is the sexualizing of feelings and experiences that are not meant to be sexual (Adams, 1996). The addict presents with an absence—or a poor set—of clearly defined sexual boundaries. Without boundaries, the sexually addictive system progresses, causing more shame and affect dysregulation. Central to the addiction model of treatment is the development of sexual boundaries that are designed to preempt the addictive cycle (Carnes, 1989). By disrupting the early phases of the addiction, sexual boundaries become a safeguard against engaging in sexually compulsive behaviors. Treatment requires specific boundaries unique to the rituals each addict uses to heighten the early arousal phases of the addiction. Clinicians will benefit from delineating specific sexual boundaries for their clients.

Shame, affect regulation, and sexual boundary development are essential building blocks of successful treatment of sexual addiction. Strategies for achieving necessary objectives in these areas are outlined.

SHAME REDUCTION

In order to assist the sex addict to reduce shame, the clinician needs to:

1. Understand the origin of the shame and its function in the addictive system.
2. Differentiate between shame and guilt.
3. Identify the defenses utilized to deny the painful feelings created by the shame.
4. Utilize specific shame reduction strategies at critical points in the treatment process.
5. Change negative core beliefs that reinforce shame.

In conceptualizing a treatment program for a sexually addicted client,

understanding the function of shame in the addictive cycle of preoccupation, ritual, compulsive sexual behavior, and despair (Carnes, 1983) is a crucial first step. Shame and guilt make up the feelings of despair and, when overwhelmed by these emotions, the addict will use the compulsive behavior until the cycle is disrupted and alternative affect coping strategies are established. Treatment designed to reduce the shame associated with the cycle is necessary with this population.

Additionally, shame is part of the core identity of sex addicts and affects how they view their needs, feelings, and sexuality. Shame has become merged with arousal in the template or love map (Money, 1986) of the individual during critical developmental periods. The addict seeks sexual experiences that are shamed based and unique to their trauma history. Here, the addiction can be conceptualized as a metaphor for the unconscious trauma (Adams, 1996). Treatment strategies must include shame reduction associated with the original trauma in the addict's life.

Differentiating between guilt and shame is important in assessing an addict's shame core and its role in the addiction. A common clinical error is the assumption that the addict's shame is primarily guilt from an overly repressive, moralistic, and punitive superego (or governing self), and that the addict should let go of the guilt and become sexually set free. Here, it is assumed that the guilt will reduce and eliminate the need for a compulsive or perverse compensation. This does not work with sex addicts. In fact, it may free the addict to do more of what he is driven to do, thereby, increasing his sense of shame and engulfing him further in the addictive cycle.

Shame, not guilt, is what drives the addictive system. While guilt ("I have done bad things") is present, shame ("I am bad, unworthy") is the primary feeling the addict is trying to medicate, rework, and compensate for. The arousal associated with the preoccupation and ritual phases of the addiction provide the escape the addict is searching. At the peak of the cycle, shame is not felt. In fact, omnipotence, grandiosity, and a false sense of esteem rise up and cover the painful experience of shame. However, once the cycle is complete, the individual has intensified his feeling of shame ("See, I really am a bad, unworthy person") and falls into more despair. Once again, the addictive system is returned to in an attempt to escape and rework the painful self-appraisals. The addictive system is strengthened, not reduced.

Defenses Against Shame

Shame is painful and causes individuals to deny its presence to self and others. Consequently, addicts frequently do not admit their feelings of shame or the behavior that caused the shame. Clinicians need to provide a caring framework and relationship that allows the addict to understand, expose, process, and reduce shame. One of the challenges for clinicians, is that the addict may not always be forthcoming with admitting, describing, and revealing the addictive behaviors that produced the shame. If a client is not

forthcoming with an admission, clinicians must be able to read the defensive structure in order to determine if the addict is in the addictive cycle. Kaufman (1980) identified six defenses against shame: rage, contempt, striving for power, striving for perfection, transferring blame, and internal withdrawal. These may be markers of an addictive cycle.

RAGE

When ashamed, the addict may rage against those around him in an effort to insulate the self against exposure and pain by transferring the shame onto others. Rage functions to keep others away so no one will suspect or question the addict's behaviors. It also allows the addict to be enraged at others rather than noticing his own feelings of shame. A spouse or family member may complain about the raging. Periodic couples or family sessions may be helpful. When clinicians sense rage in their client, underlying shame should be a consideration.

CONTEMPT

Contempt of others may be an attempt by the addict to bolster his feelings of low self-worth and self-contempt caused by the burden of shame. In viewing others contemptuously he no longer feels his own shame. Contempt can be directed at a spouse, child, or another close to the addict. It also may include groups of individuals differentiated by race, sexual orientation, or gender.

STRIVING FOR POWER

The addict may attempt to compensate for a sense of feeling defective by gaining power over others. This allows the addict to remain in control over others in interpersonal situations and prevents access to the inner, secret world of sex addiction and shame. This characteristic can be seen with addicts who exploit and violate boundaries of trust inherent in a relationship. Examples include: clergy, health care professionals, attorneys, or supervisors.

STRIVING FOR PERFECTION

After periods of acting out, shame follows. The addict may then become preoccupied with perfection to make up for a sense of not being worthy. Overmoralizing, religious preoccupation, or overcontrol regarding body functions, such as eating or exercise, may be a manifestation of this defense. The addict hopes to present an image to others of being perfect so no one suspects the hidden shame and out of control sexual behavior.

TRANSFERRING BLAME

This is a frequently used strategy by addicts who are confronted with their behavior. For example, an addict might blame his behavior on his partner:

"If you had been a better lover, then maybe I wouldn't have had to have an affair." Here, the addict transfers the shame by blaming another in an attempt to disarm the confrontation, rationalize the behavior, and avoid feeling the shame and guilt.

INTERNAL WITHDRAWAL

Addicts may withdraw and live inside themselves in an attempt to not feel the pain of the shame that would emerge in interactions with others. They appear distant and preoccupied. Withdrawal allows them to insulate themselves from others so as not to feel responsible and ashamed.

When a clinician is confronted with a significant indicator of any of these defenses with a sex addict, relapse into the sex addiction cycle should be considered. Gentle probing should be used: "Sometimes people feel ashamed about things they have done and can't see any way out of feeling bad. They try hard to hide it from others, when in fact, as difficult as it is, it is in talking about it that the release from shame happens. What experiences have you had recently that may have left you feeling ashamed or bad about yourself?"

From here, the clinician can begin to elicit more information, explore the meaning and origin of the shame and behavior, provide a framework of understanding addiction and shame cycles, and then assist in reducing the shame.

SHAME REDUCTION STRATEGIES

One of the first interventions for clinicians is to assist the addict to disrupt the addictive cycle.

Establish Rapport

Universal to all treatment, rapport is particularly important with sex addicts. Addicts must feel safe and that they will not be judged. Work to establish an understanding framework. Help them to see that they are not their behavior.

Education and Support

Educate the client about shame, its role in the addiction, defenses against it, and the risks and outcomes if it is not dealt with. Participation in a support group such as Sex Addicts Anonymous (Parker & Guest, 1999) allows the addict to expose shameful events in an accepting atmosphere along with others struggling with the same problem. This allows for the reduction of shame, eliminates the double-life phenomenon, and increases responsibility and healthy guilt. These are necessary experiences for the addict to successfully recover.

Define Powerlessness

Help addicts to understand the meaning of being powerless over their compulsive sexual behavior. This will help disrupt the faulty strategy of trying to control the forbidden impulses. Teach that control is part of control-release cycles that underlie shame based compulsive behaviors (Fossum & Mason, 1986). Here, addicts should begin to understand that control is part of the addictive cycle, not evidence of the ability to keep sexual boundaries.

First Step Inventory

The first step of the 12-step program for sex addicts is "We admitted we were powerless over our compulsive sexual behavior and that our lives had become unmanageable." Have the addict write out a first step inventory of her sexual history by listing incidents of loss of control, consequences or potential consequences of those behaviors, and feelings about the incidents. Using a timeline format, the addict can experience more fully the breath of the addiction and its consequences. A timeline exercise begins with a line drawn across a sheet of paper and marks the first experience of the addiction to the last, with all significant episodes in between; this reflects the addict's powerlessness and the addiction's unmanageability. A first step inventory can assist the addict in seeing that control has not worked and that he/she has an addiction. While grief, sadness, and loss will emerge, shame will reduce.

Face Feelings

Facing shame means facing feelings (Fossum & Mason, 1986). Underneath the painful feeling of shame are feelings of inadequacy, unworthiness, mistrust, loneliness, sadness, and anger. Help the addict develop ways to cope (affect regulation strategies) with these feelings. An increased sense of mastery will follow and feelings of adequacy and worthiness will heighten. Simple strategies like having the client breathe into his body, feel the feeling, and report the feelings will assist them in developing awareness. Dayton (2000) has outlined four steps in assisting shame based clients to unravel feelings: feel the fullness of the emotion, label it, explore its meaning and function within the self, and choose whether or not to communicate the inner state with another person.

Deal with the Guilt

As the addict begins to separate shame from guilt, it becomes time to use the guilt to guide amends toward others. In taking responsibility, the individual develops empathy for others and gains a sense of *healthy* shame. While evoking a sense of sadness and loss, making amends gives the addict important self-respect regarding behaviors that once left him feeling ashamed of himself. The amends steps (steps 8 and 9) of the 12-step program are useful

here. See *A Gentle Path Through the 12-Steps* (Carnes, 1993) for further discussion on amends making.

Shame reduces its grip when exposed in an understanding context made possible by feeling shame and other painful emotions like loneliness, sadness, and guilt related to the sexual addiction cycle. It is important that the emotions are felt fully, not just intellectualized. Without feeling and processing the painful emotions, the addict will seek to escape again through the addiction. Only by sharing the shame in a supportive and understanding context, such as a therapist office and 12-step support group, will the shame begin to lessen and provide the relief the addict needs. Sharing the shame has the additional benefit of creating bridges of attachment to part of the self the addict has felt contempt for or suppressed from awareness. In time, feelings related to the original childhood trauma begin to emerge.

TRAUMA SHAME

Shame both drives the addictive cycle and is added to by the addictive behavior. As previously discussed, reducing shame related to the addictive behavior is crucial to arresting the addiction. However, this is insufficient for long-term freedom from the addiction. Reduction of trauma-based shame is also necessary.

Shame caused by early childhood trauma through neglect, abuse, abandonment, or enmeshment becomes rooted in identity formation. Children blame themselves for failures by their caretakers. The fact that someone has failed them is assimilated as their own personal inadequacy that is reactivated in emotionally vulnerable and dependent states. Subsequent self-appraisals regarding needs, feelings, and desires are now shame-based. Here, the self is in contempt of the self (see Figure 1). The addiction becomes an attempt to compensate for this failure and to hide, from the self and others, the pain of this core shame.

This core shame needs to be felt and processed through and new beliefs about the self and others and intimacy skills must be created. Following are guidelines to assist this process.

Group Therapy

Group therapy allows for more complete healing of core shame than individual treatment alone. Typically the addict hides the shame from others. A group, however, evokes the painful feelings and memories associated with the shame and creates a safe and supportive environment for letting go of the shame and a reorganizing of the perceptions that have held the shame in place. Permission to feel, have needs, and to depend on others becomes a gateway to freedom from the shame. Expressive or experiential techniques like psychodrama (Dayton, 2000) are useful in assisting the client to feel and

process feelings rather rationalize them. Understanding alone is not sufficient to reduce shame. It is paramount for the clinician to guard against the tendency of the client to talk about the shame as evidence of healing. Shame must be felt and reprocessed in order to reduce its presence in shaping perceptions and experiences. Shame is removed from the self, and the individual begins to feel fewer urges to act-out in a shameful, sexually addictive pattern.

Expressive Techniques

Group therapy is not always available, so expressive techniques during individual treatment can become a vehicle to assist the client in exposing the emotion of shame. Art therapy, which also can be used in group therapy, is an excellent way to expose the shame (Wilson, 2000). Figure 1 is an outcome of an art therapy session in which the client was asked to draw his shame. More discussion of this case will follow. Gestalt treatments (Friedman, 1999) and Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1989) are other methods that can assist in helping the client expose and reduce shame and rework self-defeating beliefs.

Change Negative Core Beliefs

Addicts with painful shame cores of identity have negative beliefs that reflect the original trauma (e.g., people can't be trusted, I can only depend on myself, I am basically a bad and unlovable person, and sex is my most important need) (Carnes, 1983). These beliefs impair adult functioning and contribute to dysfunctional patterns of living that create an increase in the dependency on the addiction and reinforce the core shame. Introducing new, positive beliefs following the discharge and processing of feelings allows a different view of self and others to be assimilated. If the original sources of pain are not first felt and processed, cognitive techniques designed to alter beliefs have little, lasting effects. Without feeling the emotions fully, the attempt to change beliefs will amount only to the rationalization and intellectualization of the shame. The addictive cycle will eventually be leaned on again.

Shame and other painful emotions are difficult for the addict to regulate without the addictive cycle. Once the addiction is arrested, and underlying feelings and memories surface, the addict will need assistance in developing ways to regulate and respond to his internal world.

Affect Regulation

There are four major areas of consideration in the development of affect regulation as a means of assisting the recovering sex addict to develop and maintain intimacy:

1. Understanding the meaning of affect relative to other internal sensory states.
2. Understanding the significance of early developmental attachment failure on affect regulation and dysregulation.
3. Understanding the role of affect dysregulation in intimacy disorder and sexual addiction.
4. Understanding the therapeutic implications of affect regulation and the process of establishing and maintaining healthy intimacy.

The term affect regulation is gaining increased recognition and use. However, the word “affect” is often used interchangeably with other words such as emotion and feeling. It is important for both the therapist and the client to differentiate between the meanings of these words as they are so closely associated and often used in the same context. The establishment and maintenance of sexual sobriety calls for knowledge and proficiency in distinguishing between these internal states. The ability to regulate affect becomes pivotal to the recovery process. Shame reduction and boundary setting, both key components of any recovery program, depend on the ability to recognize, identify, and process strong emotional experiences.

In order to understand more completely the significance of affect regulation, researchers (Batson et al., 1992; Bradley, 2000; Goodman, 1999; Nuttall, 2000; Schwarz & Clore, 1988) have attempted to distinguish between these concepts based on either how they are formed within a particular individual or through their relative function for the individual.

The importance of affect is apparent when considering that it is affect that is responsible for awareness of internal states as it focuses attention to the stimulus that is provoking a particular affective state. It also is affect that impels one into action in response to the awareness of the affective state. It is precisely the ability to differentiate and respond appropriately to internal states that enhances the ability to develop a repertoire of behaviors necessary to relate to one’s environment.

Nathanson (1992) provides a clear delineation of affect in terms of how it originates within an individual and how it may be experienced in terms of its intensity. For example, affect describes innate responses to stimuli, which are instinctive. Feelings, however, describe the subjective experience of affect states. In this sense, feelings provide conscious representation and awareness of affective states. Emotion is described as the memories of subsequent experiences with particular affective states. It is the recollection of past episodes involving distinct affect that provides the intensity experienced as emotion, whether strong or weak. Nathanson (1992) summarizes the distinction between these three terms: affect is biology, feeling is psychology, and emotion is biography.

A practical and mutually understood categorization of these terms, like the one presented above, makes possible the recognition and description of affect and other which may be central to the content of the therapeutic

intervention. For the client, who may have been previously unaware of all but the most extreme feelings, the opportunity to develop a greater awareness of his internal realities and the ability to express them is increased. This can prove to be an important first step in reversing the damage done to the ability to regulate affect through the prolonged use of sexual behavior to manage feelings.

Van der Kolk and Fisler (1994) stresses the significance of the ability to regulate internal states as being central to self-definition and one's attitude toward his surroundings. Without a clearly defined sense of themselves, newly recovering sex addicts experience difficulty developing patterns of adaptability to situational, environmental, or event-driven stimuli. A maladaptive strategy, like sex addiction, serves to discharge or escape troublesome feelings. While unrelated to the stimulus, it becomes the primary modality for addressing emotions. The use of addiction gives rise to a different set of problems that must be managed. It ultimately creates other troublesome affects that may then reactivate the addictive process. The solution has become the problem.

The experience of abstinence from behaviors associated with sexual addiction (bottom-line behaviors) renders the recovering sex addict overwhelmed by feelings that had previously been avoided through sexual behavior. Abstinence alone is insufficient to manage strong emotional arousal due to changes to brain chemistry. Emotional arousal has been reinforced by the repetitive use of sexual behavior, which then creates urges to engage in those behaviors long after a particular behavior has stopped. Over the course of the addiction, the addict does not succeed in developing the ability to identify, differentiate, and express emotion. The therapist who is able to bridge the gap between feeling and acting helps the client tremendously by promoting the development of strategies to address strong affective arousal. Helping the client understand the impact of early attachment experiences and affect regulation can enhance this process.

AFFECT REGULATION AND ATTACHMENT

Disrupted attachment in early childhood affects children's (and eventually adults') ability to regulate affect. There is a causal relationship between the attachment patterns experienced in childhood and the attachment styles of adults. The capacity to function in healthy intimate relationships is directly related to the expectations and beliefs about oneself and others. These internal working models are created during early childhood and remain relatively constant throughout life (Bowlby, 1979).

A major task for the therapist treating a client in the early stages of recovery from sexual addiction is examining attachment patterns. Ainsworth, Blehar, Waters, and Wall (1978) identified patterns of attachment as secure or anxious. Main and Hesse (1990) later introduced another category that they

called disorganized-disoriented attachment. The relative importance of these patterns of attachment comes from the information they provide about the individual's ability to regulate strong emotion when faced with an adverse situation. In the case of anxious attachment patterns, there is an inability of the child to tolerate stressful or discomforting situations. The child either resists or avoids being comforted or soothed. Characteristics of the disorganized-disoriented attachment pattern are an inconsistent reaction to stress distinguished by confusion and an inconsistent pattern of relating to attempts to being soothed or comforted.

Linehan (1994), in her discussion of environmental factors that lead to sexual addiction (invalidating environments), proposed a set of conditions and interactions that were likely to distort development and lead to maladaptive strategies to self-regulate. A summary of these factors are presented below:

- Erratic and inappropriate responses to a child's private experiences
- Responding in extremes, that is, either overresponding or underresponding to emotional distress
- Insensitivity, unresponsiveness, or punitive reactions to communications of thought, feeling, or preference
- Strongly emphasizing the importance of controlling emotional expressiveness (especially negative emotion)
- Trivializing painful emotional experiences that are then attributed to personal flaws in the individual, in this case, the child
- A family system that is restrictive and often dismissive to the demands placed upon it by its members
- A family system that discriminates on the basis of arbitrary characteristics
- Using punishment, from criticism to sexual, physical, or emotional abuse, to control behavior
- Displaying extreme inhibition or disinhibition of behavior

It is instrumental for the clinician to understand these factors attachment failure and dysregulated affect as they contribute to the ability to accurately determine the cause of painful emotions, strongly held beliefs, or actions taken in response to either of these.

The ability to master the tasks and the ensuing emotional conflicts inherent in successive stages of development is impacted by the attachment patterns and relational styles that have been present during the progression of development. Atwool (1997) in summarizing childhood attachment irregularities writes:

> Where a child has never experienced secure attachment, their ability to trust is severely limited. Past experience is likely to mean that they are wary of adults and may expect the worst. . .they may not have internalized any of the normal rules that govern daily existence. They are likely to rely on external guidelines but their cooperation with these is by no means guaranteed.

Over the course of development, and without an internal working model developed from positive interactions with a healthy caregiver, the child may resort to maladaptive coping responses, relying only on themselves for soothing and comfort. This creates a mistrust of others to meet their needs and predisposes an individual to depend solely on external action (Goodman, 1999) to cope with the ability to respond to emotional demands of the environment. Constricted emotion (Main & Hesse 1990), and a tendency to either create or seek out experiences in their environment that are reminiscent of early invalidation, contribute to the experience of futility and hopelessness relative to attempts at making meaningful connections with others. The pervasive nature of the strongly held beliefs compels one to recreate previously experienced patterns of attachment. This helps to explain the destructive relational choices made throughout sex addiction.

Sex addicts have learned to either escape or avoid strong feelings through the addictive use of sexual behavior and, often, multiple addictions (Carnes, 1989). In the therapeutic setting it is possible to determine the pattern of acting out based of the particular type of sexual addiction a person engages in. The ten types of sex addicts engage in, developed by Carnes (1991), are summarized below as a tool to understand the different types of sexual behavior:

1. Fantasy Sex: sexually charged fantasies, relationships, and situations
2. Seductive Role Sex: seducing partners
3. Voyeuristic Sex: visual arousal
4. Exhibitionistic Sex: attracting attention to body or sexual body parts
5. Paying for Sex: purchasing sexual services
6. Trading Sex: selling or bartering sex for power
7. Intrusive Sex: boundary violations without discovery
8. Anonymous Sex: high-risk sex with unknown partners
9. Pain Exchange Sex: being humiliated or hurt as part of sexual arousal, or sadistic hurting or degrading another sexually, or both
10. Exploitive Sex: exploitation of the vulnerable

By understanding attachment and its impact on affect, an opportunity is presented to the therapist to interpret significant events and conditions that have predictive value relative to the development of maladaptive coping strategies. The clinician is provided with valuable information regarding the client's early and subsequent attachment patterns as well as the way in which sexual behavior may have been used to regulate affect. This information can be derived from a number of sources, such as the client's self-report, an intake/assessment instrument, a written first step inventory shared with the therapist, or a written sexual inventory, also shared with the therapist.

The inability to successfully moderate affective states increases vulnerability to being overwhelmed by affect and limits the ability to respond in a coordinated, organized manner specific to the experience. The person expe-

riencing affective stimuli is likely to respond in an undifferentiated manner, which includes a level of reactivity that exceeds the current circumstance. An individual with this vulnerability is further described by Gottman & Katz (1990) as having a high sensitivity to emotional stimuli, intense response to emotional stimuli, and a slow return to baseline.

This is an accurate description of what is described in addiction literature as trigger events and demonstrates how compelling the use of ritualized addictive behavior is for the person experiencing such an event. In the case of the sexual addict, sex is used to manage the level of anxiety created by the affective experience.

AFFECT DYSREGULATION AND SEXUAL ADDICTION

Diagnosis and assessment of sexual addiction will continue to occur long after the initial clinical session has taken place. The therapist needs to have a discriminating sense as to the role of attachment in the impairment of affect regulation. There are several factors that, when recognized, may be used to educate the client on the need to acknowledge the impact affect regulation has in the perpetuation and maintenance of addiction. They include the following:

1. The inability to label and modulate arousal
2. The inability to tolerate distress
3. The inability to trust one's own experiences as valid interpretations of events
4. The invalidation of one's own experiences, relying instead on external cues from the environment
5. The oversimplification of ease related to solving life's problems
6. The inability to set realistic goals (Linehan, 1994)

Magai (1999) emphasized the connection between addictive and preaddictive behaviors to help regulate affect. The use of addictive behavior allows for the distraction or the abbreviation of negative emotion. Escaping or diminishing the experience does not allow for familiarity of the situation precipitating the affective state or success at managing it. This may contribute to the development of fixed and ritualistic behaviors that consistently provide emotional relief and the release of tension.

Goodman (1999) proposes that addiction originates from impairment in what he describes as the self-regulation system. The systems he describes consists of three primary functions:

1. *Affect Regulation Functions*: these include the ability to avoid becoming overwhelmed by strong affective states with the use of self-soothing, self-enlivening, and self-arousal balancing skills.

2. *Self-Care Functions*: these involve an individual's ability to provide protection and nurturance to oneself. The ability to recognize high-risk or dangerous situations and to respond appropriately is a self-protective skill. The ability to recognize and articulate needs and to set priorities to meet them is a part of self-nurture.
3. *Self-Governance Functions*: these involve having internal beliefs, values and standards that contribute to the experience of appropriate esteem and a cohesive and consistent sense of self.

Impairment to this system predisposes the individual to over-reliance upon things external to the self to regulate the self. Bradshaw (1988) describes this phenomenon as an outer reach for inner security. Addictive behavior provides security as it relieves intense stress or anxiety, which is viewed as a threat to either real or imagined well-being. The addict's reliance upon addictive behavior demonstrates a belief that they are able to exert control over the behavior and thus calm themselves. By its very nature, however, the addictive behavior creates its own set of problems that ultimately will be dealt with in the manner in which the individual has become accustomed: addictive behavior.

A catalytic sexual event (Carnes, 1989) is associated with the development and perpetuation of sexual addiction. It becomes the unifying experience that alleviates the inner turmoil that is experienced as the inability to regulate strong affective states. The pleasure derived from engaging in sexual behavior is the additional benefit to the relief from painful experiences. The pleasure associated with the continued and escalating involvement with sexual behavior becomes the inducement to continue beyond the point that negative consequences are experienced.

IMPLICATIONS FOR TREATMENT

Development of treatment strategies to address sexual addiction must include skill building designed specifically to learn to identify and regulate emotion. In order to regulate emotion the client must learn to experience and label specific affect states and decrease the intensity of the triggering event or situation. The clinician must be able to communicate the clinical significance of this process as it relates to emotionally charged situations that can reactivate symptoms of the sexual addiction or generate behaviors related to secondary disruptive behaviors.

Emotion regulation as used here means the ability to:

1. Inhibit inappropriate behavior related to strong negative or positive affect.
2. Self-soothe any physiological arousal that the strong affect has induced.
3. Refocus attention.

4. Organize oneself for coordinated action in the service of an external goal (Gottman & Katz, 1990).

There does not seem to be one therapeutic intervention that stands out significantly from others in terms of its efficacy in dealing with affect dysregulation. It has been suggested (Bradley, 2000) that most effective intervention strategies have the result of improving the ability to regulate affect. Psychodynamic, cognitive-behavioral, or experiential techniques appear to contribute in developing a client's ability to avoid being completely overwhelmed by affect. With respect to treatment of sexual addiction, research demonstrates that the most effective strategies involve a combination of individual, group, and 12-step recovery groups specific to sexual addiction. Swisher (1995) describes the objectives for successful therapy as:

- To establish of a relationship of trust and empathy that enables and facilitates the clients' ability to come to terms with their disturbing emotional issues
- To promote an understanding of the difference between emotion, feeling, and affect
- To increase awareness regarding impairments in attachment and bonding
- To facilitate awareness regarding the relationship between disrupted bonding and the inability to development strategies to regulate affect
- To increase skills helpful in the recognition, identification, and modulation of affect
- To increase awareness of environmental, emotional, and situational stressors associated with dysregulated affect

Recovery includes the development of skills that allow for increased effectiveness with regard to self-regulation. Sexual boundary development plays an important role in assisting clients to regulate affect as well as reduce shame.

Sexual Boundary Development

One of the key components for establishing a program of recovery from sexual addiction is the development of external sexual boundaries. Here, a set of boundaries, when honored, keeps the addict from entering the ritual phase of the sexually addictive system. In doing so, the compulsive phase of the system is less likely to be activated. Boundaries need to be clear, specific to the type of pattern, and be as numerous as necessary to interrupt the system. Sharing and accountability with a therapist or 12-step member (or both) also is necessary. It is the ability to identify and maintain boundaries that promotes the awareness of self as consistent and congruent and allows the newly recovering person to set boundaries from a place of self-respect and integrity.

A mistaken belief is that abstinence is the equivalent of recovery. Clients who are not aware of the need to set appropriate boundaries may use their attempt to limit arousal or desire as evidence of recovery. Because of the shame and inability to regulate impulses to act out sexually, the newly recovering addict sees repressing sexuality as an attractive option. The reality, however, is that such behavior amounts to the use of deprivation as an attempt to exert control over the behaviors. Furthermore, while the addict may be successful in inhibiting impulses, sexual obsession and preoccupation likely will continue.

The fact that control had been previously unsuccessful during the active stage of the addiction may not be a part of the client's conscious awareness at this point in the recovery process. Control as a recovery strategy is largely unsuccessful because the deeper underlying issues related to the addiction are not addressed and remain unresolved. Further complicating this method of attempting sexual sobriety are the cycles of escalation and deescalation that are a characteristic pattern of sex addiction. That is, periods of acting out sexually may be followed by periods of aversion to anything sexual, which further increases shame, and the sense of hopelessness that had been alleviated previously through sexual behavior.

During periods of abstinence, and without a recovery plan that includes sexual boundaries, a false sense of security develops that may lead the client to engage in high-risk behaviors, believing that enough time has elapsed between acting out episodes to prevent the reemergence of the addictive behaviors. This generally proves to be untrue. A lapse in abstinence occurs, and, eventually leads to a complete return of behaviors associated with the active addiction.

Boundary setting in recovery from sexual addiction is primarily an example of self-care and self-governance, described earlier. The relevance of boundary setting to good self-care and governance is found in the recovering sex addicts' willingness to define themselves according to a newly developed set of values and beliefs that is internally oriented and structured.

Boundaries are described in *Promises of Grace: Recovery From Sex Addiction* (Sex Addicts Anonymous, 1992, p. 44) as being: "Established and set to warn us of the destructive effects of acting out and to prevent us from such destructiveness."

This example of a boundary suggest that self-care and self-governance functions are present in an individual as they engage in healthy self-protective and nurturing behaviors. It implies a shift away from external actions to provide internal comfort and the development of a belief system that is self-enhancing instead of self-destructive. The importance of boundary setting as a part of a program of sexual recovery is that it helps to recognize high-risk situations that are connected to the use of sexual behavior as a means of regulating affect. The boundary itself is used as a cue to signal potential danger and to activate and guide appropriate action.

Three Circles, Defining Sexual Boundaries in S.A.A. (Sex Addicts Anonymous, 1991) is a pamphlet that is useful in helping clients develop and maintain sexual boundaries. It provides a context for identifying behaviors for abstinence while identifying behaviors that may become a part of the healthy expression of sexuality. Examples of behaviors and boundaries in the inner circle that addicts will need to abstain from are:

- Voyeurism: cruising places formerly frequented for acting out; owning binoculars
- Masturbation with pornography: possessing pornographic materials; using any visual material for the purpose of sexual arousal
- Exploitive sex: manipulation of partner to engage in questionable behavior; coercive sexual behavior
- Solicitation: cruising areas where prostitutes are; visiting strip clubs or peep shows
- Exhibitionism: dressing provocatively, creating situations that allows others to view sex acts or behaviors

Examples of outer circle behaviors or behaviors that are not associated with the addiction are:

- Attending 12-step meetings
- Reading recovery-related material
- Journaling
- Establishing open communication with a partner and other support persons
- Developing hobbies and participating in regular exercise programs, if appropriate

Behaviors included in the third, or middle circle are those that are or have not been a part of an addictive process, but may be questionable. The purpose of the middle circle allows for continued revision of boundaries which allows for their removal and implementation whenever appropriate. It is the middle circle that represents the reality that recovery cannot be defined in black and white or extreme terms. It encourages responding to sexuality with integrity and appropriate control, while realizing and accepting that it is a dynamic and fluid experience.

Increased accountability is guaranteed when boundaries are part of a regular check-in with a therapist, 12-step recovery group, therapy group, or persons identified as part of a support network. Accountability is an important component to the recovery process. Addictive sexual patterns usually contain an absence of accountability that allowed participation in bottom-line behaviors without the threat of detection. Recovery plans that include boundaries around structure, disciplined living, and increased accountability promote the maintenance of long-term sexual sobriety and the development of intimacy enhancing behaviors.

CASE EXAMPLE

Figure 1 is a depiction of shame drawn during an art therapy exercise by a 30-year-old client struggling since early childhood with an obsessive preoccupation with masturbation and fantasies of women's violence against him that was both erotic and shameful. When he entered treatment he was masturbating 15–20 times per day and could only be sexual with a partner when he fantasized violence against him or encouraged his partner to participate in the fantasy. The drawing depicts his contempt and self-loathing for himself and the filter in which he assimilated most feelings and emotionally charged experiences.

He was unable to successfully bond with a woman and experienced break-ups as extremely painful, depressing, and riddled with a disproportionate amount of guilt and self-loathing. His preoccupation interfered with his work and was unable to advance in his career. He was unable to soothe himself in times of distress, of any type, and turned exclusively to the addiction for comfort.

Family history revealed an emotionally violent, intrusive mother and a passive father. Little nurturing was available to the client and attention was largely negative, critical, and punitive. The client witnessed open masturbation by the mother and older sister in the home. The client, while living in the home, maintained a collection of pornography that was known to other family members. He was often shamed for the collection he kept.

Treatment focused initially on the development of sexual boundaries to reduce the compulsion and allow the client to experience feelings without the use of medication. Participation in a 12-step program and the creation of specific boundaries to reduce the likelihood of engaging in the compulsion was established. Alternative affect regulation strategies were encouraged to help the client cope with the pain and shame of his addiction and family trauma. Group therapy was utilized to assist him in discharging painful affects from the past and allow him to tolerate feelings in the present and stay away from using the addictive behavior to cope. His drawing was utilized in both group and individual sessions. He used the drawing to dialogue with the shame and begin to remove himself from the shame.

In time, he began to experience the shame as something that happened to him and not something that he was. As sexual sobriety became established (over one year of complete abstinence from masturbation) memories of childhood emotional and sexual trauma began to emerge. More affect discharge work was done to deal with the memories. Cognitive restructuring to enhance new beliefs was utilized. He also established a relationship with a woman that did not include his past fantasy material.

This client's story is an example of sexual addiction developing from a lack of adequate attachment and being used as a way to cope with sexual and emotional trauma and the extreme loneliness that was incurred. However, like all sexual addiction, the solution to the problem becomes its own

problem. Treatment required addressing both the core shame and the shame resulting from the addiction for success to occur. Only after repeated intervention in both areas, did sexual sobriety occur and the ability to form an attachment and soothe internal distress become possible.

CONCLUSIONS

Sexual addiction treatment presents clinicians with unique challenges. This disorder has multiple facets to its etiology and requires multiple interventions at critical points in the process. Facing and reducing shame, developing affect regulation strategies to cope with feelings, impulses, and urges, and developing and maintaining sexual boundaries are key and necessary elements to successful treatment of sexual addiction.

Intervention of both the addictive behavior and its causes is more likely to assure success than treatment of one area over the other. In treating both the behavior and its cause, the ability to form successful attachments and assimilate feelings and life experiences through a filter of hope, love, and worthiness is greatly increased.

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