PROBLEMATIC SEXUAL BEHAVIORS 101

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Mission:
The Society for the Advancement of Sexual Health (SASH) is a nonprofit multidisciplinary organization dedicated to scholarship, training, and resources for promoting sexual health and overcoming problematic sexual behaviors.

SASH has a two-fold purpose:

• To provide up-to-date research and information to our members, many of whom are professionals and work with people who struggle with sexual addiction and compulsion.

• To provide pertinent information and education to the general public.
Disclosures & Conflicts of Interest

• Paid Consulting, Honorariums, or Financial Compensation from:
  • Travel, lodging, and meal allocation from my employer, Pride Institute.

• Specific Disclosure Statement of Financial Interest:
  • I, Todd Connaughty DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.
Definition of Recovery according to Substance Abuse and Mental Health Administration (SAMHSA)

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”
OBJECTIVES:

- Identify different theoretical models and a-theoretical models in conceptualizing problematic sexual behaviors
- Learn diagnostic issues surrounding problematic sexual behaviors
- Understand co-morbidity between problematic sexual and differential diagnosis
- Identify various global assessment(s) of problematic sexual behaviors
- Create treatment plans appropriate for the treatment of problematic sexual behaviors
- Discuss considerations related to working in the field
- Present potential new framework
Theoretical and A-Theoretical Models

- Hypersexual Disorder
- Sex Addiction
- Impulsive/Compulsive Sexual Behavior
- Out of Control Sexual Behavior (OCSB)
Hypersexual Disorder

- Excessive time consumed by sexual fantasies, urges and planning on engaging in sexual behaviors.
- Repetitive use of these behaviors in response to mood.
- Repetitive engagement in the behaviors in response to stressful life events.
- Attempts to control or reduce the behaviors.
- Disregard for the risk to self or others.
- Impairment in social, occupational or other functioning.
- Not due to other diagnosis
Hypersexual Disorder

• Masturbation
• Pornography
• Sexual Behavior With Consenting Adults
• Cybersex
• Telephone Sex
• Strip Clubs
• Kafka, Reid
Sex Addiction

- Behaviors are engaged in for longer periods of time than intended.
- An effort or desire to cut down or stop the behavior.
- Time is spent to engage in the activity or find a way to engage in the activity or recover from the activity.
- Important social, occupational, or recreational activities are given up or reduced because of the behavior.
- Continue to use the behavior despite knowledge of having a persistent physical or psychological problem.
Sex Addiction

- Recurrent use resulting in failure to fulfill obligations.
- Continued use despite problems.
- Tolerance: Defined by increased amounts of use of behavior or increase in risk.
- Maladaptive pattern of use leading to impairment or distress.
- Withdrawal: This area is least defined in sexual addiction but there is irritability when not able to engage in the behavior. Frequently depression, anxiety, and physical symptoms are present.
- ASAM now includes sex as an addiction in their definition.
Impulsive/Compulsive Sexual Behavior

- Impulsive-

There is an inability to resist an impulse, tension before engaging in the sexual behavior and a sense of release upon exhibiting the sexual behavior.
Impulsive/Compulsive Sexual Behavior

- Compulsive

Sexually compulsive behaviors are performed to avoid feelings of tension or increased anxiety.
Out of Control Sexual Behaviors (OCSB)

- Not a diagnostic Term
- Characterized by significant problems regulated sexual behavior, thoughts or urges
- Causing negative consequences
- Significant amounts of distress, shame, worry, fear and losses
- The distress does not help regulate the sexual behaviors
- Hopelessness and helplessness
- Braun-Harvey
Paraphilic Disorders

• “Non-Normative” Sexual Behaviors
• Recurrent
• Intense
• Sexually arousing
• Fantasies, Urges OR Behaviors
• Must rise to the level of disruptive or create victims (victims included in Exhibitionism, Voyeurism, Sadism, Pedophilia, Frotteurism).
Paraphilic Disorders

• Pedophilia (attraction to non developed minors—do not have to act on the attraction. Only one without remission specifier)
• Exhibitionism (sexual gratification at exposing oneself to an unsuspecting other—do not need to agree with the diagnosis the behavior is enough for the diagnosis)
• Voyeurism (sexual gratification at seeing the sexual body parts or sexual activity of an unsuspecting other—do not need to agree with the diagnosis the behavior is enough, only for 18+)
• Sexual Sadism (sexual gratification at the idea of harming others—if engaged with nonconsenting other meets diagnosis)
Paraphilic Disorders

- Sexual Masochism (sexual gratification at the idea of being harmed)
- Frotteurism (touching people for the purpose of sexual gratification while making it appear as an accident)
- Bestiality (engaging in or being sexual aroused by sexual activity with animals) (versus zoophilia)
- Fetishism and/or Partialism- (attraction to non living objects or obsession with nongenital body parts)
Possible Behaviors:

- Masturbation
- Use of singles ads/singles cites
- Masturbation in car
- Cyber sex/webcams
- Masturbation to the point of injury
- Sex with patients/clients/parishioners
- Sexual obsession/Fantasy Sex with employers
- Sexual Pornography in any form
- Sex with employees/coworkers
Possible Behaviors:

• Child Sexual Abuse images (child pornography)
• Use of drugs with sex Romantic Involvements
• Use of drugs to obtain sex
• Sex outside your primary relationship
• Use of sex to obtain drugs
• Paying for sex
• Sex with animals
• Strip Clubs Group sex/ Swingers clubs
Possible Behaviors:

- Bathhouses
- Use of urination or feces for sexual arousal
- Adult bookstores
- Phone Sex
- Sex in public places
- Obscene calls
- Anonymous Sex
- Dangerous sex (asphyxiation, sadism, masochism)
Possible Behaviors:

• One Night Stands
• Sex with minor
• Sex with family members
• Exhibitionism Voyeurism Cross-dressing
Assessment Tools:

- Hypersexual Behaviors Inventory (HBI-19; Reid 2011)
- Hypersexual Behavior Consequences Scale (Reid, 2011)
- Pornography Consumption Index (Reid, 2011)
- SAST-R (Carnes, Green, & Carnes, 2010)
- SDI-R 4.0
- ECR-R (Brennan, Clark, and Shaver's, 1998)
- Attachment Style Questionnaire
- Internet Sex Screening Test (Del Monico, 1999)
- Garos Sexual Behavior Inventory (Garos, 2008)
Assessment Tools:

- Shame inventory
- Impulsivity scale
- Self-compassion scale
- Self-monitoring Scale
- MMPI-2
- AASI-3
- Polygraph
Differential Diagnosis:

- Bipolar disorders
- OCD
- Relationship issues
- PTSD
- Paraphilia or Paraphilic Disorder
Common Co-occurring Mental Health Concerns

- Anxiety disorders
- Mood disorders
- ADHD
- OCD
- Impulse Control Disorders
- Social Anxiety
- PTSD
- Gambling
- Substance Use Disorders
- Personality Features
Intake/Global Data Gathering

• Family history
• Substance abuse
• Disordered eating
• Gambling/debting/stealing
  (12-20% of Gambling addicts are sexually addicted)
• Gaming
• Relationship history
Intake/Global Data Gathering

- Treatment history
- Medical history
- Legal history
- Religion/spirituality
- Recovery history
- General Internet use
- History of Violence
- Trauma History
- Sexual Orientation and Gender Identity history
Intake/Global Data Gathering

- Masturbation
- Pornography
- Intercourse
- Types of sexual activities
- Fantasies/Attractions
- Consensual/Non-consensual
Case Conceptualization:

• What is the function of the problematic behavior?
• What is the primary diagnosis?
• What are the secondary diagnoses?
• What are the systemic concerns?
There is no one way to treat a sex addict!
Presentations are wide and varied
It’s not just about stopping the behaviors
Group versus Individual
Mindfulness • ACT • Trauma Informed Care • CBT/Relapse Prevention • Schema Informed Therapy • Co-Occurring Issues • Motivational Interviewing
Treatment and Treatment Planning

• Start with your history
• What are most risky issues right now? Legal, Medical, Substances, Sexually, Family
• What coping mechanisms do they have in place and how to build on that?
• What areas of accountability are needed?
• What are the mental health concerns that need to be addressed and monitored?
• What sexual education has to be done?
• What more “digging” needs to be done in sexual behaviors?
• What Personality Disorder Traits are there?
• What interpersonal skills need to be built?
Treatment and Treatment Planning:

- What supports are needed (consider 12-step)
- What emotional intelligence work?
- What is the clients shame?
- What trauma/abuse history needs to be addressed?
- What are their sexual health goals?
- What empathy work needs to be done?
- What family/couples work needs to be done? Disclosure?
- What grieving work needs to occur?
- What areas do you need education
Working with Partners, Spouses, and Supports

- Most clients had encouragement from loved ones to come to treatment.
- It is very important, yet very difficult, to establish rapport with spouses/partners, without going too far.
- The spouse will need help with education on the disease, recovery, relapse prevention. However, you need to ensure you maintain boundaries.
- Spouses often feel a level of trauma, mistrust, abuse and have resultant symptoms. Be mindful of labeling them either traumatized or co-addicted/co-dependent.
- Except in very rare instances, there should be 3 clinicians involved with clear roles, boundaries and systems in place.
- Boundaries, boundaries, boundaries, boundaries (yours, hers, his and theirs!)
Working with Parents:

• Crucial work! Very fine line between support, good parenting and smothering or sponsoring.

• First work with your client to gauge their perspective of what might be useful, beneficial, supportive.

• Many clients don’t want to nor need to tell their parents about their trauma history or to express how it was growing up in the household. Some may need to and have to be okay without validation.

• Have to help the whole system look at the system dysfunction and where to go while honoring the system’s fears and hurts due to our clients behaviors
Substance Use and Sex:

- Substance abuse history is common in this population, either clients are co-occurring or switched.

- 40-60% of individuals with PSB’s report substance use disorders
Substance Use and Sex:

- Sexual behavior during the use of drugs is common and quite frequently risky

- Higher incidence of sexual risky behavior while under the use of stimulants

- One study found that men in DA treatment stated that their drug use and sexual behaviors were strongly intertwined

- Drug use increases the desire or preoccupation with sex

- Drug users have an expectation that drug use will enhance their sexual interactions and performance

- Those in DA treatment without a component of reducing risky sexual behavior are more likely to engage in substance abuse sexual activity, with casual partners and do not enjoy sex as much as when sober
Special Considerations:

- Avoid pathologizing clients and their behaviors.
- Awareness of your own personal biases
- Boundaries
- Self-care
- How do you measure success?
Special Considerations:

- If you are uncomfortable with any topic, don’t do that work!
- Use preventative measures to guard against counselor burn out or PTSD,
- Participate in personal and professional development,
- Recognize and examine own biases,
- Recognize and examine own sexuality, what you have known (and done) will become an issue!
- Be mindful that your own sexual attitudes and beliefs are not being put on the client. Don’t work with certain populations if you disagree with their version of healthy sexuality.
- Function as a member of an interdisciplinary team
- Have a working definition of sexual health
- Need to be curious! Ask questions
A Theory-Neutral Framework for Conceptualizing PSB’s:

- Does not replace other models
- Consider this a professional assistance model
- Does not require diagnosis or labels
- Does not require loss of self-control
A Theory-Neutral Framework-Five Categories of PSB:

Frame work describes the sexual behavior as problematic if it consistently:

1. Conflicts with a person’s commitments and/or
2. Conflicts with a person’s values and/or
3. Conflicts with a person’s self-control
4. Results in negative consequences and/or
5. Lacks sexual responsibility.
A Theory-Neutral Framework-Five Categories of PSB: Discussion of the Framework
Q&A

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