
# THE PERFECT STORM: ASSESSING FOR SEX ADDICTION

By Patrick J. Carnes, PhD

A common observation in sex addiction treatment groups by patients is, "I wish my earlier therapists had known about sex addiction." This complaint usually is about lost time, money spent and deteriorating circumstances. When the losses are great, such as a divorce that is now seen as unnecessary or a positive HIV status that could have been avoided, therapists' lack of knowledge is perceived as part of the problem. In essence, if a past therapist had been more aware, perhaps all of these costs could have been avoided.

Experienced therapists respond by pointing out to the patient the web of lies that sex addicts weave around their compartmentalized lives. To vilify your past therapist when you have not told him or her the whole story may be a convenient piece of denial, but the truth is therapy does not work well without the whole picture. A further truth we know empirically is that addicts can take up to two years or longer to commit to a treatment process even though they know they inevitably have to face it. One of the hallmarks of that period of "pre-contemplation" is to see a therapist and be a non-committed client (Carnes, 2005). Most often something has to happen so disastrous, so painful and so costly, the addict accepts the inevitable. In other words, commitment starts with the "perfect storm" in which things combine to make for the worst situation. We see these very "messy" situations which appear around us every day. Sexual revelations appear about a very visible political leader and the scandal fills the media with speculation. The talking heads express surprise at the uncharacteristic lack of judgment of someone whose integrity seemed unimpeachable — but maybe was. Consider church leaders whose efforts to spread God's word become compromised with painful witnessing to their sexual failures. Or worse we learn of the rabbi spirited off to Israel or the priest to Rome so that their vulnerability to charges might evaporate if they were off the public's radar.

Business leaders, educators at a high school level, physicians, clergy, college professors, day care professionals, law enforcement personnel — these are our most trusted people whose sexual behavior is now revealed. Discussions around sex become volatile because sex is our species' most primal activity — i.e. to reproduce ourselves. The imperative to reproduce requires responsible behavior, so the reactions are intense when trusted people break trust. We prefer to see them as unusual situations that are catastrophic and rare. We see it as the "perfect storm" which requires unusual conditions and is therefore rare. It is cultural denial. It is in front of us every day and we prefer to see it as aberrant and unique. The truth is these situations are often the proverbial tips of an iceberg called sex addiction.

When sex becomes an addiction problem, the behavior deeply threatens our most important social bonds. Parallel processes, such as compulsive overeating causing obesity in over a third of our adults, do not generate huge outcries. Yet, sex does. The fact that 4,300 adolescents might start using drugs

every day does not get much of a reaction, but sex does. The fact that 16 percent of graduating seniors from high school are at risk for pathological gambling does not grab headlines, but sex does. Sex is so core to our species' survival that it has been hard to appreciate when it can be addictive. So when it is, it creates a significant reaction. The social turmoil around sexual problems has all the makings of that perfect storm.

From a scientific point of view, we now understand so much more. We know that the brain categorizes sex 20 percent faster than any other stimulus (Anokhin, Golosheykin, Sirevaag, Eristjansson, Rohrbaugh & Heath, 2006). We know that sex taps into the same neural chemical processes other addictions do (Carnes, Murray & Charpentier, 2004; Cozolino, 2006; Fisher, 2000). We now have large samples that allow us to understand the etiology of the problem (Carnes, 1991). We have many researchers who have looked at treatment (Carnes & Adams, 2002), etiology and a medical journal dedicated to the problem.

Further, cybersex has accelerated the problem so that most clinicians, sooner or later, have someone present sexually compulsive behavior as a problem (Carnes, 2003). Even the mainstream press is reflecting our growing understanding of sex addiction as part of the large panoply of addictive disorders (Lemonick, 2007).

However, when clinicians have to confront the problem, there will be reactions because it is about sex. So when the perfect storm hits, therapists need to be mindful of what to look for so they too are not caught up in the turmoil. Consider the following situations:

• A 54- year-old man is about to come into a significant inheritance. He has struggled with alcohol and drug addiction. He is mostly sober now. However, he gets paid on Thursday. By Thursday night he has blown all of his paycheck on strippers in a nearby strip bar. He literally does not have food for the next week. His inability not to spend money on prostitution has his family very concerned about his inheriting a great deal of money.

• The wife of a CEO of a very large corporation gets an anonymous letter telling her of an affair her husband is having. She finds evidence it is true. Her husband is traveling at the time. She calls him in the middle of the night to confront him and realizes that he is with yet another woman. By the time he comes home, she has ransacked phone and credit card records and has discovered there are many women. When he walks in the door, she physically assaults him.

• An emergency room physician is working in her third hospital because of affairs with other doctors. Although married to a physician, she is now involved with one of her husband's partners. When her husband discovers this,he commits suicide in their garage.

• A brother (age 8) and sister (age 10) go on the family computer and discover a pornographic movie that their father had forgotten to remove from the hard drive. They had been watching for almost a half-hour when discovered by their mother. She removes the computer and has it analyzed only to discover that her husband was averaging close to 40 hours a week downloading pornography. Since he worked at home while she and the kids were gone during the day, she had no idea. But it helped to explain why the income from his consulting business had declined from a robust six figures to less than half of what she made as a high school teacher.

• A patient comes into rehab her fifth time for cocaine abuse and alcoholism. She knows she does not have another run in her. She has a secret. No therapist has asked her how she acquires her cocaine. She buys it from the male escorts she hires off the Internet and meets in hotels in the afternoon before her kids come home from school. She realizes that this secret has to come out or she will not make it.

• An inadvertent touch of a switch left the three-hour tape on the answering machine run while an 18-year-old high school senior was on the phone. Horrified parents learned painfully of their daughter's many partners including older men on the Internet, miscarriages, her participation in a "barely legal" escort service and her extensive drug use.

• A sheriff is arrested for child pornogra-

**Table 1: Addiction Diagnostic Criteria**

| | |
|---|---|
| 1. | Recurrent failure (pattern) to resist impulses to engage in specific sexual behavior. |
| 2. | Frequent engaging in those behaviors to a greater extent or over a longer period of time than intended. |
| 3. | Persistent desire or unsuccessful efforts to stop, reduce, or control those behaviors. |
| 4. | Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experience. |
| 5. | Preoccupation with the behavior or preparatory activities. |
| 6. | Frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations. |
| 7. | Continuation of the behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior. |
| 8. | Need to increase the intensity, frequency, number, or risk of behaviors to achieve the desired effect, or diminished effect with continued behaviors at the same level of intensity, frequency, number, or risk. |
| 9. | Giving up or limiting social, occupational, or recreational activities because of the behavior. |
| 10. | Distress, anxiety, restlessness, or irritability if unable to engage in the behavior. |

## Table 2: SAST-R Core Items

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | 1. | Were you sexually abused as a child or adolescent? |
| ☐ | ☐ | 2. | Did your parents have trouble with sexual behavior? |
| ☐ | ☐ | 3. | Do you often find yourself preoccupied with sexual thoughts? |
| ☐ | ☐ | 4. | Do you feel that your sexual behavior is not normal? |
| ☐ | ☐ | 5. | Do you ever feel bad about your sexual behavior? |
| ☐ | ☐ | 6. | Has your sexual behavior ever created problems for you and your family? |
| ☐ | ☐ | 7. | Have you ever sought help for sexual behavior you did not like? |
| ☐ | ☐ | 8. | Has anyone been hurt emotionally because of your sexual behavior? |
| ☐ | ☐ | 9. | Are any of your sexual activities against the law? |
| ☐ | ☐ | 10. | Have you made efforts to quit a type of sexual activity and failed? |
| ☐ | ☐ | 11. | Do you hide some of your sexual behaviors from others? |
| ☐ | ☐ | 12. | Have you attempted to stop some parts of your sexual activity? |
| ☐ | ☐ | 13. | Have you felt degraded by your sexual behaviors? |
| ☐ | ☐ | 14. | When you have sex, do you feel depressed afterwards? |
| ☐ | ☐ | 15. | Do you feel controlled by your sexual desire? |
| ☐ | ☐ | 16. | Have important parts of your life (such as job, family, friends, leisure activities) been neglected because you were spending too much time on sex? |
| ☐ | ☐ | 17. | Do you ever think your sexual desire is stronger than you are? |
| ☐ | ☐ | 18. | Is sex almost all you think about? |
| ☐ | ☐ | 19. | Has sex (or romantic fantasies) been a way for you to escape your problems? |
| ☐ | ☐ | 20. | Has sex become the most important thing in your life? |

## Table 3: Professional Resources

| Organization | Description |
|---|---|
| *These critical resources exist for professionals who wish to learn about sex addiction:* | |
| **Society for the Advancement of Sexual Health (SASH)**<br>www.SASH.net / SASH@SASH.net<br><br>Founded in 1987 by Patrick Carnes, Richard Santorini and Ed Armstrong, The Society for the Advancement of Sexual Health (SASH) is a nonprofit organization dedicated to promoting public and professional awareness and understanding of addictive/compulsive sexual behavior and its associated negative consequences. SASH provides access to education, information and referral resources, encouraging wellness for all those they serve. | *This is the professional society for clinicians, researchers and policymakers, as well as the interested public.* |
| **International Institute for Trauma & Addiction Professionals (IITAP)**<br>www.IITAP.com / Info@IITAP.com<br><br>IITAP's mission is to provide cutting-edge training and promote the highest level of professional standards among practitioners worldwide who treat individuals with sex addiction and associated disorders. In addition, IITAP's role is to facilitate the Certified Sex Addiction Therapist (CSAT) Certification Program, as well as other educational programs. | *The International Institute for Trauma and Addiction Professionals (IITAP) is the source for certification as a Certified Sexual Addiction Therapist (CSAT), and the task-centered approach to treatment. Training is also provided for other addictions, as well.* |
| **Journal for Sexual Addiction & Compulsivity**<br>http://www.tandf.co.uk/journals/titles/10720162.asp<br><br>The first and only journal devoted to topics pertaining to this growing illness, ***Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention*** is a quarterly, peer-reviewed journal that provides a forum for research and clinical practice. As *the* source for information in this expanding new field, the journal gives practicing clinicians useful and innovative strategies for intervention and treatment from the necessary multidisciplinary perspective. | *The Journal, in its twenty-first years, has been a critical venue for research, clinical directors and policy issues, and is published by the oldest medical publishing company in the world.* |

phy. Among his current duties included being the team leader in the unit responsible for investigating child pornography in the county. The press has a field day. The wife and children are traumatized by the public reaction.

• A beloved clergyman confesses to a large congregation of 13,000 people that he has been having affairs with parishioners and staff. His apology was public with his wife and elementary age children present.

The stories are legion. Almost always, even the patients observe that so many unusual things happened to create the crisis they were in. They almost perceive their situation as though the very worst possible combinations of events occurred all at once. They did not expect it. In that sense, they are like the characters in Sebastian Junger's novel, *The Perfect Storm*, (also a movie by Warner Bros.) *The Perfect Storm* was horrendous because of the rare concurrence of weather events. The fishermen who headed into the storm had no idea it would be so bad. While the patients may describe their lives this way, in fact their experience is fairly common. Here is why their lives seem like a perfect storm.

*The truth emerges.* Addiction can only thrive in deception. Sex addiction, especially, requires compartmentalization and duplicity. Addicts believe in secrecy as the solution. Yet there really are no secrets. Something happens to expose the reality. Usually this creates a reaction in those around the addict.

*Efforts at damage control by the addict make it worse.* Living in compartmentalization and denial, addicts acknowledge the truth only in bits and pieces as they have to. Thus they will be dishonest in the hope that no more facts come out. Then, as more facts emerge, they have to admit to more lies which undermine what remaining credibility they have. Spouses frequently refer to this as an experience akin to Chinese water torture. They are worn down by the dishonesty. This process even occurs with their therapists. The term "disclosure testing" is used by clinicians to describe how the patient will reveal only as much as they believe their therapist has to know or can handle for the time being. If the therapist "passes the test" then the client will be ready to reveal more.

*Spouses and loved ones become seasoned investigators.* The pattern of distrust and heightened anxiety forces loved ones into being obsessed about the addict. They become forensic accountants and investigators in an effort to

find out the truth. Unfortunately, they are rewarded in that there is usually more to discover. For some time clinicians have been discussing the net effect the trauma of disclosure has on the spouse, partner or family. In sex addiction the wounding is amplified. It is by comparison easier to understand if someone chooses alcohol over you, but if the disease is about other sexual partners, it is harder to accept. Yet truth and full disclosure does help because it lays bare that the addict clearly has a problem (Corley & Schneider, 2002; Minwalla, 2008).

*Others join in the reactivity.* Many others become involved. Employers, financial institutions (misuse of funds involved), state professional and licensing boards, churches and law enforcement head up a long list of the potential stake holders in the recovery process. The irony for the therapist is that bad decisions will require damage control. While the quest is for honesty, decisions will have to be made over who gets access to what information. For example, does the employer need to know all the details, even if it involves other employees or key elements of the business? If the media is involved, reactivity can become exponential.

*Children are involved.* There are often complications about what children know or should know. Part of the dilemmas stem from developmental issues about children's readiness for sexual information. Sometimes children know about addictive sexual behavior before adults do. Certainly protection of children heightens the reactivity of families and concerned others (Carnes, S., 2008).

*Co-morbid issues exist.* Very few sex addicts have just one addiction. Most have other dual diagnosis mental health issues including depression, post-traumatic stress disorder and personality disturbance. All of these add to the situational complexity as well as to clinical acuity. So, in the midst of the swirl of the storm, how does a therapist keep an eye on discerning if sex addiction is the problem? The key question here is whether all the chaos is unique or is there an underlying pattern of addictive disease. Certain key questions will help determine if you need to do further assessment:

• *Has the patient a history of seeking help for sexual issues?* A high probability exists that the patient more than likely has been talking to others about the problem for some time.

• *Has the patient a history of shame and deception around these issues?* A characteristic of most sex addicts is hidden, secretive behavior. This is not about cultural perception, inhibition or lack of sexual awareness. It is a pattern of having to hide something that is clearly self-destructive.

• *Is there preoccupation?* The patient will report difficulty in setting aside sexual thoughts to the extent that obsession prevents normal life functioning and meeting of routine obligations. The clinician can assume the brain has achieved a new "set point" which interferes with decision making. These "judgment errors" are core to the addiction process.

• *Are there consequences?* Loss of control is one of the key signs of addiction's presence. Choices that clearly will have bad consequences; promises to self and others to stop; and inability to learn from past behaviors become important elements in life unmanageability. The term "compulsive behavior" is used in this context as one of the critical signs of addictive illness.

• *Are family members or friends upset over sexual behavior?* Relationship disturbance is one of the high correlates of sex addictions presence.

• *Is there significant affect disturbance?* Depression and suicidal ideation lead the list of collateral problems for sex addicts. Grief, trauma, and guilt often fill in behind despair.

**Table 4: Self-Help Resource List**

| Organization | Phone | Website |
|---|---|---|
| Sex Addicts Anonymous<br>ISO of SAA<br>P.O. Box 70949<br>Houston, TX 77270 | (713)869-4902<br>(800)477-8191 | www.sexaa.org<br>Info@SAA-Recovery.org |
| Sexual Compulsives Anonymous<br>P.O. Box 1585<br>Old Chelsea Station<br>New York, NY 10011 | (800)977-HEAL | www.sca-recovery.org |
| Sex and Love Addicts Anonymous<br>Fellowship-Wide Services<br>1550 NE Loop 410, #118<br>San Antonio, TX 78209 | (210)828-7900 | www.slaafws.org |
| S-Anon<br>P.O. Box 111242<br>Nashville, TN 37222-1242 | (800)210-8141<br>(615)833-3152 | www.sanon.org |
| Co-Dependents of Sex Addicts (COSA)<br>International Service Organization of COSA<br>(or ISO of COSA)<br>PO Box 14537<br>Minneapolis, MN 55414 | (763)537-6904 | www.cosa-recovery.org<br>Info@COSA-Recovery.org |
| Co-Dependents Anonymous<br>http://www.codependents.org/contacts.php | (602)277-7991 | www.codependents.org |
| Sexaholics Anonymous International<br>P.O. Box 3565<br>Brentwood, TN 37024 | (866)424-8777<br>(615)370-6062 | www.SA.org<br>SAICO@SA.org |
| *For additional sexual addiction resources visit:* | | www.SexHelp.com<br>*Created by noted psychologist and author Dr. Patrick Carnes, this site will help those affected by sexual addiction and compulsivity - whether it be the addict or the friend or loved one of the addict - and provide new insights into sexual addiction and resources for recovery.* |

If these key issues are present, the clinician may wish to use standard diagnostic criteria for assessing the patient for sex addiction. These criteria (listed in Table One) parallel the criteria used for substance abuse and pathological gambling. They have been used for some time to diagnose sex addiction (Carnes, 2000; Carnes, 2003). Various studies report that most sex addicts score above three of the criteria. For example, in an inpatient population of 1,267 — 803 men, 349 women and 115 homosexual men — 96 percent of them were assessed as meeting three or more criteria. The sample average score on the SAST-R was 6.81. The assessment was a consensus between a psychiatrist, nurse and patient. A good practice is to review the criteria with the patient and talk about how the patient's life either fits or does not fit the criteria.

Another approach is to use the Sexual Addiction Screening Test or SAST. Developed in the early 1980s, the SAST was very effective at identifying male heterosexual addicts (Carnes, 1989). Efforts to create SAST-like instruments for women and homosexual men did not result in researchable constructs that were also clinically useful. Based on tens of thousands of clinical

| Table 5: Recommended Reading | |
|---|---|
| Title | Author(s) |
| *Contrary to Love - Helping the sexual addict* | Patrick Carnes |
| *Cruise Control - Focused on sex addiction in the gay community* | Rob Weiss |
| *Disclosing Secrets - An important research based discussion of the disclosure process* | Deborah Corley<br>Jennifer Schneider |
| *Don't Call it Love - A summary of a study of 1000 sex addicts and their families* | Patrick Carnes |
| *Facing the Shadow - One of the first guides to therapy for the sex addict* | Patrick Carnes |
| *In the Shadows of the Net - The second edition of how addiction manifests in cyberspace* | Patrick Carnes<br>David Delmonico<br>Elizabeth Griffin |
| *Mending a Shattered Heart: A Guide for Partners of Sex Addicts - An edited volume of the most frequently asked questions from family members* | Stephanie Carnes |
| *Open Hearts: Renewing Relationships with Recovery, Romance & Reality - A couples approach to recovery* | Patrick Carnes<br>Debra Laaser<br>Mark Laaser |
| *Out of the Shadows - The original guide for sex addicts* | Patrick Carnes |
| *Ready to Heal: Women Facing Love, Sex & Relationship Issues - A heartfelt book addressing women dealing with relationships, sex and love addiction* | Kelly McDaniel |
| *Sex Addiction: Case Studies and management - A classic on sex addiction issues* | Ralph Earle<br>Marcus Earle |
| *Sexual Addiction - A well done guide to sex addiction from a faith based context* | Mark Laaser<br>Debra Laaser |
| *The Clinical Management of Sex Addiction - An edited volume on treatment and special populations* | Patrick Carnes<br>Kenneth Adams |
| *The Porn Trap: The Essential Guide to Overcoming Problems Caused by Pornography - An excellent new book which focuses specifically on internet pornography* | Wendy Maltz<br>Larry Maltz |
| *Untangling the Web: Sex, Porn and Fantasy Obsession - An excellent guide to internet sex* | Robert Weiss<br>Jennifer Schneider |
| *When He's Married to Mom - A guide to a very common sex addiction profile* | Kenneth Adams |
| *Comprehensive Textbook of Psychiatry*, Vol. 1. Sadock & Sadock, editors. Sexual Addiction: Chapter 18.4. | Patrick Carnes |
| Bargains with Chaos: Sex Addicts and Addiction Interaction Disorder. *Sexual Addiction and Compulsivity: The Journal of treatment and* | Carnes, P., R. Murray & L. |

and non-clinical populations, a new SAST-R has been developed with the intent of being equally effective across gender and orientation. In a series of preliminary studies this instrument shows great promise at being able to accurately identify sexually-addicted individuals in populations of clergy, college students, outpatients, inpatients, and other non-clinical populations.

The SAST-R is composed of 20 core items proven to discriminate across gender and orientation. These core items are listed in Table Two. The SASTR contains an additional 25 items currently described as research scales. These sub scales collect nuances of male, female and orientation behavior as well as identify clients whose problems are internet based. Also, there are scales which measure four critical factors in addiction: preoccupation, loss of control, relationship disturbance, and affect disturbance. Together they form an additional profile to supplement the core items, diagnostic criteria, and the therapist's clinical judgment. Therapists can access the original SAST as well as the new SAST-R by going to www.sexhelp.com or www. iitap.com. They can download for their patient the complete instruments along with instructions to score. Or they can simply instruct their patient to take the instrument on line at sexhelp. com and the instrument will be automatically scored. Because of the applied nature of this article the psychometric properties of both instruments have been omitted. Those wishing to explore item development, reliability, validity, research progress, and research collaboration will find all current information at www.iitap.com.

A further data-based assessment does exist called the Sexual Dependency Inventory or SDI. Based on over 200 specific sexual behaviors,this instrument is designed to help the clinician do an in-depth assessment of the client's behavioral patterns. While taking a SAST is a matter of a few minutes the SDI takes a couple of hours.

The easiest way to access this process at this point is to contact a Certified Sex Addiction Therapist (CSAT) in your local area. To find a CSAT therapist or to learn about training to become a CSAT go to www.sexhelp.com or www.iitap. com and click on "Find a Therapist."

If working with sex addiction is new for you, a wealth of professional resources exists to assist you, as well as extensive self-help resources to which you can refer your client. Table Three lists professional resources and Table Four Lists Self-Help resources. Table Five lists a selected bibliography of books and key articles which will help back fill what a therapist will need in order to be as effective as possible.

A common observation made by most therapists who get involved with this work, is that once you understand the problem, you read headlines very differently. You recognize that what appears as a uniquely catastrophic "perfect storm" really is the harbinger of another reality. The reality of addiction has lit up another dark corner of our human existence. The hopeful part is that help can be given. The most important part is that helping professionals can see through the chaos of families hurting and help to restore trust in our most basic human processes. If we can do that with solid assessments, sound clinical judgments, and clinical support, we will, storm by storm, illuminate the problem for everyone

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