INTERVENTION and the Sexually Compulsive Patient

by James Fearing, Ph.D., C.C.D.P.

There are many unique clinical challenges and complexities faced by the therapist or professional interventionist when intervening the sexually compulsive/sexually addicted patient. Important awareness regarding the painful impact and destruction consistent with this compulsive disorder has grown dramatically throughout this past decade. The clinical research and associated information brought forth has precipitated a need for further development, distribution and implementation of the appropriate intervention strategies and/or treatment processes. An important question often asked is; "Should a professional intervention be planned if the sexually compulsive patient is acting out, and he or she is in denial?"

Due to the combination of social sensitivity and the existing negative public perceptions associated with sexually addictive behaviors, it has not been an easy field for which to enlist outside support. At times, it has been treated more like a "hot potato," which only gets handled when there is no possible way to avoid it. Unfortunately, the deep shame that accompanies this disorder, combined with the denial factor, sets up a psychological barrier which blocks the sexually compulsive person from asking for help. In evaluating the clinical integrity of providing professional intervention in this area, this dynamic provides insight. In some cases there may be no other possibilities for the suffering sex addict to receive help other than intervention.

Similarities with Other Addictions

Individuals who suffer from sexual compulsivity/sexual addiction may display many symptoms similar to those of people affected with other addictions. Until recently, this disorder remained in the background for many healthcare providers as well as the general public. Today, more people understand those who are affected by this disorder. People are witnessing the extreme emotional pain, physical health risks, destroyed careers and deep shame associated with sexually compulsive behavior. Unfortunately, it has taken high-profile cases such as Hollywood celebrities, professional athletes, TV evangelists and national politicians to gain the needed attention. It is still commonplace for the media to misrepresent sexually compulsive behavior. It is primarily masked or camouflaged as bad boy/bad girl behavior. Seldom is it reported as an addiction or obsessive-compulsive disorder within the disease concept. Due to sensationalized reporting practices, the focal point never reaches past the scandal or problem, and therefore never accurately discusses the illness and treatment.

There are many similarities between sexual addictive behavior and the more commonly treated addictions. One commonality seen in all addictive behavior is an attitude of denial, combined with the continuous demonstration of a "loss of control." This loss of control is present regardless of the painful, negative consequences experienced when acting out this compulsive behavior. This produces the dynamic of feeling powerless, extreme mood swings and painful isolation. It is not uncommon to hear a patient describe the "rush" that is experienced prior to and during the compulsive behaviors as somewhat like the effect of getting high on drugs. The person often feels a physiological change within themselves that many times ends in a severe let-down or depression.

The Shame-Based Disease

One of the most predominant features consistently experienced by the sexually addicted person is the presence of overwhelming shame. While shame, to some degree, is a common characteristic found in all addictions, this specific disorder is fully cloaked and grounded in shame. At a deep emotional level, the sexually addicted person experiences an inner conflict with his or her perception of the moral codes of society. This inner turmoil, combined with the continual pathological patterns of acting out, produces inconsistencies within their own core belief system. This contrast with "normal sexual behaviors" produce shame, low self-esteem and painful internal conflicts. In facilitating interventions in this area, it is extremely important for the clinician to understand the strong connection between shame and sexually compulsive behaviors. This dynamic also can be predominant in the members of the system around the patient.

The Dysfunctional System

There are many unique complexities associated with intervening the sexually compulsive patient and the associated "system." In facilitating this type of intervention, the therapist/interventionist will be most effective in using a systems-orientated framework for their clinical foundation. Although it may be inviting for the clinician to get hooked into the initial details reported, there will normally be many valuable answers and pieces to the puzzle beneath the original script. In other words, look beyond the obvious in formulating your

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intervention/treatment plan. Typically, you will find more than just one identified patient emerging from this dysfunctional system. It may prove helpful to examine the reasons why spouses, sex partners, friends, etc., end up in relationships with the sexually addicted person. The participating person may be unaware of the reasons behind their selection process of friends, partners, etc. If the therapist can access the appropriate information, it will help everyone involved take the necessary steps to receive help. Examples of topics and concerns commonly encountered when preparing and executing the intervention are: rape, sexual abuse, sexual identification, drug and alcohol abuse, AIDS-HIV questions, physical abuse, children at risk, repressed memories, etc.

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Pre-Intervention

Proper preparation for an intervention in which the primary diagnosis is sexual compulsivity/sexual addiction is critical. An initial telephone screening should be facilitated at the onset of the intervention process. The main objective of this screening or staffing is to establish the appropriateness and potential feasibility of scheduling an intervention. This conversation normally takes place between the "point person" who initiated the first call and the therapist/interventionist. This conversation provides the clinician with any information that may necessitate evaluation prior to assembling the "team members." There may be information that could be emotionally damaging to someone participating in the intervention. This information may still need to be accessed by the therapist/interventionist, but would not be appropriate to bring out in front of the team. It is never advisable to place anyone participating in the intervention at risk either emotionally or physically for the sake of attempting an intervention.

The Intervention

Because of the denial factor, secrets, shame and isolation, professional intervention may be one of the only options for successfully helping the sex addict get help. It is not uncommon for the sexually addicted patient to verbalize what a relief it is after the intervention has taken place stating, "I knew I was sick, and I couldn't stop, yet I did not know what to do or where to go for help. I felt so alone and hopeless." The intervention process presents a reality-based vehicle to break through this altered perception.

It is extremely important for the professional involved to remain dedicated to the original objective of the intervention. The specific intervention goal is to mirror the addicts' compulsive behavior back to them to break through their denial system. This is followed by the respectful facilitation of admission for treatment of the identified patient and family. If the therapist/interventionist crosses the clinical boundary into areas of marriage therapy, psychotherapy or diagnosis, there is a great risk of forcing the process too fast without the benefit of having the appropriate clinical foundation in place to support the information. This may jeopardize or sabotage the possibility of future benefits normally gained from the therapeutic process of a well-timed contained disclosure and/or appropriate amends.

In determining the overall success of any intervention, it is recommended the therapist/interventionist guard against setting up team members to place all the importance on whether or not the individual identified patient enters treatment. The fact that everyone involved has had an opportunity to become educated, to put a voice to their feelings, and to begin setting boundaries to break through the denial in itself is a victory.

It is critical that the professional working with the intervention team includes information to help them understand that this is an illness and not lack of will power or a moral issue. Upon intervening the identified patient, he/she will most likely admit to having tremendous levels of shame, and there is no need to magnify the existing shame. It is my opinion that the healthiest choice anyone can make when learning about someone's sexual compulsivity is to begin the intervention process as soon as possible.▼

Intervention Screening Profile Questions

1. Identified patient profile. Discuss any past consequences, pending legal action, prior treatments, family and/or partner knowledge and involvement, outsiders knowledge, physical health issues, psychological profile, etc.

2. Confidential screening of potential intervention team members. Who are the appropriate people to engage in this sensitive process? How much do you disclose at this stage? It is the responsibility of the team leader to initiate all contacts once the screening is complete, and the potential team is mutually agreed upon. The therapist/interventionist may be open for legal repercussions if he/she contacts friends, colleagues, or family of the identified patient.

3. Geographic location and timing. When is the best time to plan the intervention? What about pre-existing plans; i.e. vacations, holidays or work commitments, etc.?

4. Discuss appropriate treatment provider options. Financial issues, insurance benefits etc. Are there any other untreated addictions, (i.e. chemicals), or potential depression, suicidal ideation or past history of suicide attempts?

5. Discuss private information and confidentiality. This gives the organizer the opportunity to discuss any details which may be inappropriate to bring out in the presence of the team.

6. Schedule the pre-intervention meeting and intervention.

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