

WOMEN and *Sex* ADDICTION



BY PATRICK J. CARNES, PHD

For years people have regarded sex addiction as primarily a male problem. Yet the numbers have remained steadily parallel to those found in alcoholism and gambling: for every three men there was one woman. In recent years that has changed. In treatment, our female patient population has equaled and sometimes exceeded our male patients. The most concrete empirical evidence of this shift has been recent large studies of Internet sex in which problematic cybersex behavior by women was over 40 percent. Most striking is the fact the actual behaviors of women are shifting, as well as the numbers.

In early 1991 I wrote a paper summarizing data at that point which contrasted the types of behavior men and women sex addicts would chose. While by no means discrete, it was clear that men tended towards “behaviors that objectify their partners and require little emotional involvement.” Specific examples of these behaviors would be anonymous sex, prostitution, pornography, exhibitionism, and fratteurism. Women

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on the other hand, tended towards “behaviors that distort power — either in gaining control over others or being a victim.” Examples here would include sexual conquest, working as prostitutes, and sadomasochism. The article was clear, the evidence was straight forward, and the dynamics rooted in cultural dynamics most professionals could understand (Carnes, 1991).

Many of those trends persist. At the same time there are emerging new trends which confound patterns we researched for decades. We are seeing more “male” types of behavior including pornography collections, compulsive use of prostitutes, and a new level of aggressiveness in approaching prospective sex partners. Much speculation exists as to why these new patterns are happening. For example, does

cybersex play a role? To go to an adult book store to seek out sex, would usually be higher than most women’s risk threshold. But to view pornography and initiate contacts within the safety of your own home on the Internet creates a new anonymity. Some have suggested that it represents shifts in culture and sexual mores. Current data on adolescent development is being reported which includes earlier sexual behavior and more non relational sex. Women are exercising greater freedom which can manifest in compulsive behavior. We are far from knowing the extent or etiology of all these changes. Yet, it is important for clinicians to be aware that these shifts are occurring.

Consider the story of Angie, a 45-year-old woman who had been in treatment for alcohol three times, and in treatment for eating disorders once. She entered sex addiction already with the recognition that her alcoholism was a way to soothe her self after high risk sex. In her art therapy she drew a picture of herself diving into water after high risk sex, the water representing her alcohol use. She was clear that

her bulimia was driven in part by her obsession to be attractive to men. She also had issues with spending which often were connected to her sexual acting out or preparing to act out.

Angie was physically abused by her father, usually in the form of whippings with her father's belt. Much of her most abusive sexual behavior as an adult involved men's belts. She was gang raped as a young teenager and as an adult placed herself in high risk situations where she would be assaulted by a number of men at the same time. After her first rape experience she was so distressed she was institutionalized, which she describes as a period of great isolation. She typifies a component of most sex addict's experience in that her behavior was often driven by eroticized rage. Sexual behavior is often angry and victimizing. Yet, the sex addict notices the pleasure and obsession but not the anger. This dynamic of anger stems often from early childhood and adolescent experiences. They fit St. Paul's description of people who struggle with their sexuality as "children of wrath." While Angie was angry about many things that have angered women for eons, the way she manifested represents new patterns (Carnes, 2001).

As an adult she was college educated, married, and lived in a wealthy neighborhood. Because of her husband's means, she devoted herself to raising their three children — at least ostensibly. Reality was that she organized her day around sexual acting out. Compulsive masturbation and cybersex usually happened in the morning. These behaviors would be punctuated by shopping and food restriction. Drinking and drug use would precede the hiring of a male escort or prostitute in the afternoon. If her husband was traveling, she would hit the bar scene in the evenings to pick up someone. One of her many examples of more "male" like behavior is that she would argue with her escorts because they wanted to use

a condom and she wanted to experience sex without any "barrier."

Her art work about her sexual behavior almost always split her substance abuse and her sexual behavior. This compartmentalization is typical for abuse victims but also represent two sides of the same coin. In addiction medicine we are growing in our appreciation of the ways addictions "interact" (Carnes, Murray, Charpentier, 2005). In her drawing Angie is soothing herself with alcohol after high risk sex. High intensity and arousal followed by numbing is a common pattern in which one addiction flows into another. In other drawings Angie illustrates the "parallel" tracks of her chemical dependency and her sexual acting out. We call this "fusing" because the addict seldom does one addiction without the other. Angie always started using a few hours before her major sexual episodes of the day.

In search of patterns

Larger patterns become clear by contrasting women with and men, both gay and straight. One of the key issues to be aware of is that sexual aversion or "anorexia" (DSM - 302.79) is a frequent companion to sexual addiction. Like eating disorders, the binge/purge phenomenon is common, as is restriction in the form of compulsive sex avoidance. In treatment we encounter all three — addiction, avoidance, and binge/purge cycles. Frequently we find all three either in the patient's history or current behavior. A patient might, for example, binge outside of the primary relationship but be compulsively non-

sexual with the person they love. Thus, they are bingeing and purging at the same time.

When contrasting presenting problems by gender, it becomes clear that women are much more likely to experience the anorexic side of the continuum. Gay males also struggle with the issue. Heterosexual males have the least amount of aversion, but over one-third of the population still have trouble. Table One provides an overview of the distribution of anorexic as well as addictive behavior on our sexual disorders unit. Notice that 70 percent of women were admitted for the sexual anorexia issue whereas just short of 60 percent presented with sexual addiction.

Another critical factor for women sex addicts is the presence of other addictions, as our story of Angie illustrates. Comparing men and women in terms of their other addictions also raises intriguing patterns. The biggest discrepancy is around eating disorders where women are higher in both bulimic/anorexic and compulsive eating categories. While men tend to work more and use nicotine less, the figures are not nearly so discrepant as those involving food. Table Two shows other addictions present in an inpatient population of sex addicts.

Another interesting set of contrasts emerge when comparing women in an inpatient setting with a large sample of women who completed a self assessment online. Both samples used an instrument called the Sexual Addiction Screening Test, revised specifically for women. Out of the 25 items, the score

Table One

	FEMALE % "YES" (N=590)	MALE % "YES"	GAY MALE "YES"
ASSESSMENT – SEXUAL ADDICTION	59	90	94
ASSESSMENT – SEXUAL ANOREXIA	70	36	48

of 13 was used as a criteria for the presence of addiction. In this contrast, patients and online assessments had at least a score of thirteen. The data is summarized into two tables. Table Three shows those variables in which both populations are roughly parallel (within 15 percentage points). Variables such as abuse history, current abuse, and relationships are strikingly similar.

Table Four presents variables in which the differences really become extreme. The pattern here is important because in all cases the online assessments show much more distress than even those women in an inpatient setting. The questions in which there are discrepancies are most often diagnostic inquiring about consequences, efforts to stop, and hiding behavior.

The most obvious interpretation is that there are a number of highly distressed women who have not been able to bring themselves to treatment.

Another explanation might be that anonymity affects how people respond to the items. A third possibility is people “faking” more distress, although the sample size would argue against it. What minimally can be said is that both inpatient and online data indicate that female sex addiction as a significant clinical problem.

The codependency wild card

Partners and family members of sex addicts struggle with codependency as well, which often obscures women and their sex addiction. Co-sex addiction is a more reactive state than codependency to other addictions. If someone chooses alcohol over you, it is very difficult. The difficulty is compounded if your partner chooses other sex partners over you. The “wrath” of betrayal is catalyzed exponentially if the codependent is also acting out but has not yet been discovered. Sometimes we are

angriest with others — with that which we hate in ourselves. Consider the following examples:

- Jane comes to treatment because she cannot stop obsessing about her husband’s sexual behavior even though he is showing success in his recovery. In treatment she starts to admit staying involved with old boyfriends she had as far back as in high school. She also has been involved with the couple’s parish priest. She finally admits that part of her righteousness was to prevent admitting what she was doing.

- Sandra was in treatment for her drug addiction and met another patient with whom she fell “madly in love.” They leave treatment together and go on a major drug binge. Her new love goes online and involves her in threesomes, in which she is asked to do risky and unprotected sex. He became physically and emotionally abusive. She at first maintains that the behavior was because of her obsession with him and their drug use. Over time she admits to a long history of acting out, in which this was but another episode.

- Astra was very angry with her husband because he was having compulsive and unprotected sex with men in adult book stores. In family week she admits to going online, having phone sex, and meeting men on a nearby beach. During these encounters she has unprotected sex. When it is pointed out to her that unprotected sex on the beach is no different than unprotected sex in the porn shops, she is outraged. She believes that the men she was with were safer.

These examples show being obsessed with your partner can add to personal denial about your own behavior. Clinicians need to be mindful how coaddiction works and separate out what is addiction and what is coaddiction. In the late 1980s and early 1990s I followed 1,000 families for seven years. Out of that research nine variables emerged in the co-addiction process.

Table Two

OTHER ADDICTIONS	FEMALE % "YES" (N=588)	MALE % "YES" (N=894)	GAY MALE % "YES" (N=121)
Alcoholism	46	46	49
Bulemia/ Anorexia (food)	27	5	8
Caffeine Addiction	37	37	33
Compulsive Eating	34	18	20
Compulsive Spending/Debting	36	27	41
Compulsive Violence/Raging	18	14	12
Compulsive Working	29	37	36
High Risk Behavior/Danger	30	33	46
Nicotine	34	26	26
Substance Abuse	41	40	54

Table Three

CONTRAST OF INPATIENT AND ONLINE ASSESSMENTS — SIMILAR		
QUESTION	INPATIENT FEMALE % "YES" (N=585)	ONLINE FEMALE % "YES" (N=4979)
1. Were you sexually abused as a child or adolescent?	57	57
2. Have you stayed in romantic relationships after they became emotionally or physically abusive?	75	74
3. Does your spouse (or significant other) ever worry or complain about your sexual behavior?	58	59
4. Do you ever feel bad about your sexual behavior?	79	89
5. Has your sexual behavior ever created problems for you and your family?	63	76
6. Have you ever sought help for sexual behavior you did not like?	28	28
7. Has anyone ever been hurt emotionally by your sexual behavior?	66	79
8. Have you ever felt degraded by your sexual behavior?	75	86
9. When you do have sex, do you feel depressed afterwards?	60	50
10. Has your sexual activity interfered with your family life?	46	58

Table Four summarizes supporting data for each path reported by partners in the study (Carnes, 1991). By looking at these variables it helps to identify what questions to ask about the partners reactivity to sex addiction. Now we need to look at what key questions can we ask about sex addiction itself.

Nine paths to coaddiction

All coaddicts share nine processes in common. These processes are paths to powerlessness and unmanageability, and thus to coaddiction. They are signs that coaddiction is present.

1. *Collusion.* Most coaddicts actively support the addiction by covering up for the addict in some way. Powerful childhood rules about family image and secrecy have helped make them unwitting partners in the addictive process. Over two-thirds of our survey respondents kept secrets about the addict.

Over one-half actually lied to cover up for the addict’s behavior. Nearly three-quarters said that they actively worked to present a united front to the world. Another form of collusion was evidenced by the 37 percent who reported becoming “hyper” sexual in an effort to join with the addict.

2. *Obsessive preoccupation.* Coaddicts obsess about addicts and their lives. Thus, 62 percent of our survey respondents found themselves constantly thinking about the addict’s behavior and motives. Moreover, 58 percent actually played detective, by checking mail, purses, and briefcases. A similar percentage found themselves so obsessed they would forget about other things. Over two-thirds clearly saw that their obsession was a way to avoid their own feelings.

3. *Denial.* When not obsessing, coaddicts lapse into ignoring the reali-

ties around them. In our survey, 83 percent mentioned setting aside their intuitions, while 43 percent said there were periods in which they totally denied the problem. Nearly three-quarters indicated that they would keep extra busy and overextended to avoid the problem. Despite failures, over two-thirds maintained the belief that they could eventually change the addict.

4. *Emotional turmoil.* Life for a coaddict is an emotional roller coaster. Approximately three-quarters of coaddict respondents indicated they went on emotional binges, that at times their emotions were simply out of control, and they experienced free-floating shame and anxiety. Almost two-thirds agreed with the statement that they always had a crisis or problem.

5. *Manipulation.* Coaddicts become manipulative in their drive to control their partner. Of the coaddict

Table Four

CONTRAST OF INPATIENT AND ONLINE ASSESSMENTS — DISSIMILAR		
QUESTION	INPATIENT FEMALE % "YES" (N=585)	ONLINE FEMALE % "YES" (N=4979)
1. Do you often find yourself preoccupied with sexual thoughts or romantic day-dreams?	57	92
2. Do you feel that your sexual behavior is not normal?	37	53
3. Do you have trouble stopping your sexual behavior when you know it is inappropriate?	50	88
4. Have you ever worried about people finding out about your sexual activities?	63	91
5. Have you made efforts to quit a sexual activity and failed?	38	78
6. Do you hide some of your sexual behavior from others?	61	93
7. Do you feel controlled by your sexual desire or fantasies of romance?	36	73
8. Do you ever think your sexual desire is stronger than you are?	39	79

respondents, 61 percent recognized that they had tried and failed to control their partner's sexual acting out. The same number admitted using sex to manipulate their partner or patch up disagreements. Over half made threats to leave but never followed through. Almost all saw themselves as having played martyr, hero, or victim roles.

6. *Excessive responsibility.* In their obsession, coaddicts were extremely tough on themselves. Over three-quarters blamed themselves for the problem. Sixty-two percent believed that if they changed, the addict would stop. The same number took responsibility for the addict's behavior. In addition, many would actually seek extra responsibility; 59 percent indicated that they created dependency situations where they would be indispensable.

7. *Compromise or loss of self.*

Coaddiction involves a constant series of compromises, which erodes one's sense of self. Thus 59 percent of our coaddicted respondents acted against their own morals, values, and beliefs. A full 61 percent gave up life goals, hobbies, and interests. Over one-half changed their dress or appearance to accommodate the addict. Forty-three percent accepted the addict's sexual norms as their own.

8. *Blame and punishment.* Coaddicts become blaming and punishing in their obsession. Almost two-thirds of coaddicts surveyed perceive themselves as having become progressively more self-righteous and punitive. Twenty-one percent had affairs to punish the addict or to prove that they were worthwhile and attractive. Over one-half saw their behavior as destructive to others. Perhaps the best indica-

tor of coaddictive vengeance was the 36 percent who admitted to homicidal thoughts or feelings.

9. *Sexual reactivity.* Coaddicts went to various extremes in reacting sexually to their partner's behavior. Predominant, however, was the impulse to close down sexually. Over two-thirds of our respondents reported numbing their own sexual needs and wants. Over one-third would change clothes out of the addict's sight. Forty-three percent would make excuses not to be sexual. Two-thirds rarely felt intimate during sex.

TRAP DOORS: A clinical interview process

Clinicians have been seeking key questions to help in the assessment process for sex addicts. This type of interview would be similar to the CAGE process for alcoholism. Nine variables were identified out of a data set of 1,600 inpatients and 80,000 online assessments. These questions work for all patients regardless of gender or orientation. The variables have been placed to form the acronym TRAP DOORS which is in part acknowledgement of the difficult and unforeseen consequences that sex addicts often face. These variables become a series of questions which help diagnose and determine the severity of the addiction. The key questions are:

- Have you ever sought *Treatment* for problematic sexual behaviors? (Prior efforts to seek help is a key variable.)
- Have any of your *Relationships* been damaged or disturbed as a result of your sexual behavior? (Almost always there is a concern about relationship damage.)
- Were you sexually *Abused* as a child or adolescent? (Sexual abuse is a key antecedent for compulsive sex.)
- Are you *Preoccupied* with thoughts about sex? (Preoccupation is

one of the defining issues in diagnosis.)

- Do you experience any symptoms of *Depression* because of your sexual behavior? (Despair, remorse, and feelings of hopelessness result from failure to manage sexual behavior.)

- Do you feel like your sexual behaviors are *Out of Your Control*? (Loss of control is another key defining variable for determining addiction's presence.)

- Have you ever felt the need to keep your sexual behavior *Out of Sight*? (Hiding behavior and living a double life characterize the sex addict's experience and deep distrust.)

- Have you engaged in dangerous, illegal, or otherwise *risky sexual behaviors*? (Sexual risk is one of the hallmarks of sex addiction.)

- Have you experienced *Shame* because of your sexual behavior? (Feeling defective is core to the sexual addict's inner world.)

These questions provide a diagnostic process for the clinician and a spring board for discussing treatment. Throughout the assessment process therapists must now examine any stereotypic images of what men and women do sexually. For it is clear that sex addiction in women is not only more prevalent, but the shades of behavior are becoming less distinct between men and women. Therefore it is critical to focus specifically on the addictive process, and not be distracted by what the specific behaviors are. This is why assessment processes like TRAP-DOORS are very helpful in a time of great sexual change. ☉



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Table Five summarizes the preceding list and gives data from the survey for the nine characteristics of coaddiction.

NINE CHARACTERISTICS OF COADDICTION

COADDICTIVE CHARACTERISTICS	TYPES OF BEHAVIOR	% COADDICTS
1. Collusion	Joined addict to present united front.	71
	Kept secrets to protect addict.	66
	Lied to cover up for addict.	53
	Became hypersexual for addict.	37
2. Obsessive preoccupation	Focused totally on addict to avoid feelings.	67
	Constantly thinking about addict's behaviors and motives.	62
	Checked addict's mail, purse, briefcase, etc.	58
	Forgetful.	57
3. Denial	Denied personal intuitions.	83
	Kept overly busy and overextended.	72
	Believed I could eventually change addict.	68
	Totally denied the problem.	43
4. Emotional turmoil	Emotions were out of control.	79
	Went on emotional binges.	78
	Experienced free-floating shame and anxiety.	74
	Always had a crisis or problem.	63
5. Manipulation	Played martyr, hero, or victim roles.	92
	Used sex to manipulate or patch disagreements.	61
	Failed efforts to control sexual acting out of partner.	61
	Made threats to leave but never followed through.	54
6. Excessive responsibility	Blamed myself.	75
	Believed if I changed, addict would stop.	62
	Took responsibility for addict's behavior.	62
	Created dependency situations where I was indispensable.	59
7. Compromise or loss of self	Gave up life goals, hobbies, and interests.	61
	Acted against own morals, values, beliefs.	59
	Changed dress or appearance to accommodate addict.	53
	Accepted addict's sexual norms as my own.	43
8. Blame and punishment	Increasingly more self-righteous and punitive.	64
	Destructive to others.	54
	Homicidal thoughts or feelings.	36
	Had affairs to punish the addict or prove worth.	21
9. Sexual reactivity	Numbed my own sexual needs and wants.	68
	Rarely felt intimate during sex.	66
	Made excuses not to be sexual.	43
	Changed clothes out of sight of addict.	34