



Spring 4-12-2013

# LOOKING FOR ATTACHMENT SOLUTIONS IN ALL THE WRONG PLACES: OUT OF CONTROL SEXUAL BEHAVIOR AS A SYMPTOM OF INSECURE ATTACHMENT IN MEN

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## **Abstract**

Hypersexual behavior is often misunderstood and minimized, and we continue to lack an understanding of what underlies this behavior. Without an understanding of the function of hypersexual behavior, we cannot ascertain the most effective treatment. This study was designed to examine the underlying function of such behavior by exploring whether insecure attachment in men relates to the development of hypersexual behavior. A total of 45 men who were assessed as having Out-of-Control Sexual Behavior (OCSB), utilizing the recently proposed Hypersexual Disorder (HD) diagnosis were compared to 32 men who did not present with OCSB. Participants were directed to an online survey where they completed assessments for hypersexual behavior (The HBI) and attachment style (The ECR-S). Multivariate analysis indicated that high ECR-S scores predicted high HBI scores, high HBI scores tended to show high levels of attachment avoidant behavior and that high ECR-S scores were predictive of the clinical determination of HD. High scores on attachment avoidance, rather than attachment anxiety, were most predictive of the clinical determination of HD. Overall, the avoidant behavior score was a better predictor of OCSB than were attachment anxiety scores. Hypersexual behavior may be a particular manifestation of avoidant attachment and it is this underlying issue that must be addressed to effectively treat HD.

## **Degree Type**

Dissertation

## **Degree Name**

Doctor of Social Work (DSW)

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## **Keywords**

sexual behavior, sexual addiction, attachment style, insecure attachment, sexual compulsion, sexuality

## **Subject Categories**

Social and Behavioral Sciences | Social Work

LOOKING FOR ATTACHMENT SOLUTIONS IN ALL THE WRONG PLACES:  
OUT OF CONTROL SEXUAL BEHAVIOR AS A SYMPTOM  
OF INSECURE ATTACHMENT IN MEN

Michael Crocker

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2013

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ATTACHMENT IN MEN

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Michael Crocker

## DEDICATION

This dissertation is dedicated to all the clinicians and participants who gave their time and shared their experiences for the benefit of increasing the understanding of difficult behaviors that many judge or minimize. Out-of-control sexual behavior has left people alone, empty, unemployed, homeless, and hopeless. For some, it has been this behavior that led them to chronic self-destruction and eventual suicide. Behavioral symptoms are communicating important messages. The clinicians and participants who have given their time to this study are helping us to discover the meaning of these symptoms.

“Who we are and who we become depends, in part, on whom we love.”

Lewis, Amini, and Lannon (2000, p. 144)

## ACKNOWLEDGMENTS

I would like to thank Dr. Phyllis Solomon for her constant support and direction. She helped me travel down this unnerving, winding road, especially at times when I wanted to give up and find easier ways out. She kept me inspired toward the goal of providing a meaningful contribution to the field. I was not always easy to guide, yet she kept at me and helped me find my way.

I also would like to thank the director of the DSW program, Lina Hortocollis, as well as the faculty of the program. This program has changed me in ways that I would have never imagined. The DSW program helped me to arrive at a new understanding of the importance of connection, attachment, and love. This was accomplished not only through the results of this study but also through the support and love of my teachers and colleagues. Additionally, I thank my committee members, John Giugliano and Andrea Doyle, who guided and supported me through this process and kept reminding me of the importance of this study. Gratitude goes out to my colleagues Gladys Foxe, PhD, Art Baur, LCSW, Michael Aaron, PhD, Gail Bach, PhD, and Jason Fletcher, PhD who helped me stay grounded, focused, and hopeful.

The 2009 DSW Cohort, of which I was a member, had an uncanny ability to psychologically hold all of its members in a way that allowed each one of us to give birth to studies that held great personal meaning. I specifically would like to thank cohort members Di O'Neill, Lauren Depinto, and Bianca Harper. Without the unwavering support that they provided, this accomplishment would never have been realized. This doctoral program has forever changed my ideas of friendship, support, humility, and pride.

My mother passed away while I was completing this study and finishing my doctorate. She had been a presence in our class throughout the studies of the 2009 Cohort. She continues to

reside in my soul and character. She has everything to do with the fact that I was able to accomplish this. Thank you, Mom.

Finally, I would like to thank my life partner, Shaun Peknic. Shaun has helped me find attachment in the right place. He helped me discover the meaning of love and rediscover a sense of home and safety. His pride for me helped me to believe in myself.

## ABSTRACT

### LOOKING FOR ATTACHMENT SOLUTIONS IN ALL THE WRONG PLACES: OUT OF CONTROL SEXUAL BEHAVIOR AS A SYMPTOM OF INSECURE ATTACHMENT IN MEN

Michael Crocker

Phyllis Solomon

Hypersexual behavior is often misunderstood and minimized, and we continue to lack an understanding of what underlies this behavior. Without an understanding of the function of hypersexual behavior, we cannot ascertain the most effective treatment. This study was designed to examine the underlying function of such behavior by exploring whether insecure attachment in men relates to the development of hypersexual behavior. A total of 45 men who were assessed as having Out-of-Control Sexual Behavior (OCSB), utilizing the recently proposed Hypersexual Disorder (HD) diagnosis were compared to 32 men who did not present with OCSB. Participants were directed to an online survey where they completed assessments for hypersexual behavior (The HBI) and attachment style (The ECR-S). Multivariate analysis indicated that high ECR-S scores predicted high HBI scores, high HBI scores tended to show high levels of attachment avoidant behavior and that high ECR-S scores were predictive of the clinical determination of HD. High scores on attachment avoidance, rather than attachment anxiety, were most predictive of the clinical determination of HD. Overall, the avoidant behavior score was a better predictor of OCSB than were attachment anxiety scores. Hypersexual behavior may be a particular manifestation of avoidant attachment and it is this underlying issue that must be addressed to effectively treat HD.

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## CHAPTER 1

### OUT-OF-CONTROL SEXUAL BEHAVIOR

My failures have made me look at myself in a way I never wanted to before. It's now up to me to make amends, and that starts by never repeating the mistakes I've made. It's up to me to start living a life of integrity. I once heard, and I believe it's true, it's not what you achieve in life that matters; it's what you overcome. Achievements on the golf course are only part of setting an example. Character and decency are what really count. Parents used to point to me as a role model for their kids. I owe all those families a special apology. I want to say to them that I am truly sorry. It's hard to admit that I need help, but I do.

Tiger Woods, TPC Sawgrass Clubhouse, Ponte Vedra Beach, Florida, February 19, 2010  
("Full transcript," 2010)

On February 19, 2010, Tiger Woods apologized to the world for allowing his sexuality to get out of control. He admitted to multiple affairs and offered his recognition that he had disappointed his family, friends, and community. The notion that an individual's sexual behavior can get out of control has become commonplace in the mental health field as well as in media reports. News of high-status professionals, celebrities, politicians, and sports icons' putting their lives, relationships, and careers at risk for the sake of sexual dalliances is an everyday occurrence. It is clear that these behaviors cause individuals great harm, personally, interpersonally, and occupationally.

#### **Background of the Problem**

Sexual behavior normally enhances lives through providing a connection, intimacy, and enjoyment. However, for some, it leads to disconnection, isolation, and despair due to feeling that their sexual behavior is out of control. Krafft-Ebbing (1886) described the existence of this behavior over one hundred years ago. Now, over a century later, we still lack an understanding of what drives these sexual behaviors to become so out of control. This introductory section

includes an overview of the various ideologies related to out-of-control sexual behavior (OCSB) as well as the social construction of the diagnostic label of sexual addiction.

Hypersexual behavior is often misunderstood and minimized, and we continue to lack an understanding of what underlies this behavior. Without an understanding of the function of hypersexual behavior, we cannot ascertain the most effective treatment. Attempts to theorize about these sexual behaviors have included understanding them as a compulsion (Coleman, 1990), an addiction (Goodman, 1998), a symptom of trauma (Carnes, 1991a), a psychobiological disorder (Ragan & Martin, 2000), an impulse control disorder (Barth & Kinder, 1987), and a manifestation of affect-regulating difficulties related to an insecure attachment style (Katehakis, 2009).

This study was designed to examine the underlying function of OCSB. In an effort to contribute to a deeper understanding of this baffling behavior, this study investigated the relationship between OCSB and insecure attachment. Building on the theoretical position of Katehakis (2009), the researcher hypothesized that men with OCSB will most likely present with a compromised attachment style that has led them to this behavior as a strategy for connection without the risk of facing their fears of intimacy. Specifically, the hypothesis is that men with an insecure attachment style will be more likely to present with OCSB than will men with a secure attachment style. The research question concerns whether male participants who were assessed as having OCSB were more likely to be assessed as having an insecure attachment style than were men who presented without OCSB.

Numerous studies have been conducted and conceptual articles written in an effort to understand the origins and function of OCSB. The study of this behavior became particularly charged as researchers and clinicians rushed to demonstrate the existence of this condition, with

the hope of its inclusion in the *Diagnostic and Statistical Manual V (DSM-V)* (Delmonico, 2001). The majority of those who have joined this effort believe that this condition is an addiction and that the *DSM-V* should acknowledge it as such. However, this will not be the case; instead, the *DSM-V* development committee proposed that they would consider classifying this behavior as a Hypersexual Disorder (Kafka, 2009). Kafka's proposal includes the following diagnostic criteria:

- (1) Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors in association with three or more of the following five criteria:
  - a. Time consumed by repeatedly indulging in sexual fantasies, urges or behaviors which interferes with other important (non-sexual) goals, activities and obligations.
  - b. Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
  - c. Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events.
  - d. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, or behaviors.
  - e. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.
- (2) There is a clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, or behaviors.
- (3) These sexual fantasies, urges, or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medicine). (p. 3)

Kafka's (2009) proposal for inclusion of OCSB in the *DSM-V* as a Hypersexual Disorder has been a disappointment for those who had high hopes that it would be included as an addictive disorder. These hopes stemmed from the belief that classifying OCSB as an Addictive Disorder would lead to a more comprehensive understanding of its etiology and more effective treatment (Delmonico, 2001). The diagnostic label of Hypersexual Disorder, although

descriptive, does not, however, lend itself to a rich understanding of the function and cause of the disorder. Nevertheless, the *DSM-V* planning committee has rejected the proposal for inclusion of Hypersexual Disorder and has recommended that these symptoms receive more research to understand their etiology and presentation. There are, however, aspects of the definition of Hypersexual Disorder that lend viability to looking at this disorder through the lens of attachment theory, particularly the notion of sexual behavior's being used to manage affect regulation. Affect regulation is integrally connected to attachment theory (Siegel, 1999)

Even prior to the efforts toward *DSM-V* inclusion, the issue of out-of-control sexual behavior was highly polarized because this disorder, whatever we call it, involves sexuality. The issue of sexuality often activates emotional and moralistic responses in even the most objective clinician. For these reasons and many others, OCSB needs to be studied in depth. In the last ten years, there have been increasingly more efforts in this regard.

Researchers and clinicians (Carnes, 1983, 1991a; Goodman, 1998; Wines, 1997) have attempted to explain OCSB as indicative of an addiction to sexual behavior. This theorizing relates to the idea that OCSB has the capacity to provide a neurochemical high as well as an escape from painful affects, both of which result in the sexual behavior's becoming addictively driven. Others (e.g., Katchakis, 2009) provide explanations that concern a more in-depth understanding of the individual and his or her history and interpret the sexual behaviors as an expression of issues that are more emotional than sexual. Examples include the explanation of OCSB as a manifestation of an affect disorder (Weiss, 2004), a symptom of trauma (Carnes, 1991a), or an expression of dissociation (Griffin-Shelly, Benjamin, & Benjamin, 1995). Recently, there has been burgeoning interest in looking at the connection between OCSB and

attachment styles that interfere with intimacy and connection (Katehakis, 2009; Zaph, Greiner, & Carroll, 2008).

### **Prevalence of OCSB**

Data on the prevalence of OCSB are difficult to collect due to the complexity involved in defining OCSB, and, as a result, such data are scarce. Additionally, OCSB often may be hidden due to shame and, paradoxically, normalization of these behaviors, particularly with men. It has been estimated that 3–6% of the general population may suffer from OCSB (Carnes, 1989; Coleman, 1992); however, the authors who cite these statistics do not indicate how they obtained this information. In particular, no epidemiological studies of OCSB exist. Cooper, Delmonico, and Burg (2000) looked at the prevalence of OCSB in those who were engaging in cybersex and found that 17% of their sample of 9,265 individuals identified as having OCSB. Meadows (2002) found that 14% of substance abusers also display OCSB. It should be noted that all of these studies were performed with men. Goodman (1998) reviewed multiple addiction-related studies that he felt, taken together, revealed significant psychological characteristics that are shared by individuals with alcoholism, drug addiction, bulimia, pathological gambling, and OCSB. This resulted in his asserting that OCSB, similar to these other conditions, has an addictive quality.

Although Goodman (1998) asserted that the majority of individuals with OCSB are men, he did not cite any epidemiological studies that support this statement. More recent research, however, has begun to look at how OCSB may present in women (Ferree, 2001; Kasl, 1989; Ross, 1996, 2000; Schneider, 2001; Schneider & Schneider, 1991). Ferree believes that OCSB in women is more hidden as compared to men due to the stigma associated with women and sexual behavior.

## **The Social Construction of Sex Addiction**

OCSB is widely believed to be an addiction (Carnes, 1989, Goodman, 1998), although controversy surrounds this notion. In the past decade, the public has been exposed frequently to media reports of celebrities' displaying OCSB. Public discourse concerns whether these individuals are seeking the easy way out, using addiction as an excuse for their immoral and irresponsible behavior.

Prior to OCSB's reputation as an addiction, it was subsumed under the diagnostic category of perversions (Goodman, 1998). This diagnostic category existed for decades, and the stigma attached to this diagnosis effectively kept individuals who were struggling with this issue underground. Additionally, prior to advances in technology, acting on such behaviors could more easily be kept secret. This is seen in the differences between the John F. Kennedy and Marilyn Monroe situation as compared to that of Bill Clinton and Monica Lewinsky. Advances in technology also have exacerbated OCSB through increased access to pornography and to a variety of sexual opportunities, resulting in what some consider a mental health crisis (Carnes, Delmonico, Griffin, & Moriarity, 2001).

The notion of OCSB as an addiction was popularized by the publication of Patrick Carnes's (1983) *Out of the Shadows: Understanding Sexual Addiction*. This was the first self-help book written specifically for individuals who suffer with OCSB. Carnes developed the first in-patient facility to treat individuals who present with sexual addiction and then became instrumental in the development of similar facilities across the country. Carnes is considered a pioneer in the field of OCSB and views OCSB as a behavioral addiction, not unlike a substance addiction ("Patrick Carnes, PhD, CAS Biography," n.d.).

Carnes has a doctorate in counseling education and organizational development, and his theories reflect his organizational and educational orientation (“Patrick Carnes, PhD, CAS Biography,” n.d.). His theory on OCSB is based on a cognitive approach that involves the identification of negative core beliefs about one’s self-worth. He theorized that these negative core beliefs make an individual vulnerable to becoming addicted to sexual behavior (Carnes, 1983). His theory incorporates a cycle of addictive behavior that starts with affective discomfort, moves toward a preoccupation with sex and a ritualized preparation for sexual acting out, and concludes with the sexual behavior and a return to affective discomfort. According to Carnes, the affective discomfort is exacerbated by shame and guilt, which activate the cycle again. Carnes’ model incorporates the use of 12-step programs to recover from this addiction.

Carnes became a prolific author on this topic and presents at workshops, speaks at conferences, and appears as a guest on many talk shows. He also was instrumental in the development of the first peer-reviewed journal on sexual addiction. Further, he spearheaded the development of a national organization, originally known as the National Committee on Sexual Addiction and Compulsion, now known as the Society for the Advancement of Sexual Health (SASH). This name change was a result of the controversy surrounding the function of this behavior. SASH holds an annual conference that includes workshops on the various understandings and ideologies of OCSB and the best treatment practices (“About Us,” n.d.), with a slant toward treating OCSB as an addiction.

Carnes’ (1991a) model later included research that helped identify the etiology of this addiction. He concluded that many individuals with OCSB had been victims of sexual, physical, or emotional abuse. He connected this abuse with his earlier formulation of negative core

beliefs. This became a common conceptualization of the cause of OCSB, which will be discussed in a later section.

Due to the popularity of Carnes' (1983, 1991a) conceptualization of OCSB, most OCSB treatment models utilize his model. There are now hundreds of inpatient and outpatient programs that specialize in the treatment of sexual addiction (Ryan, 2010). According to Ryan, these programs utilize the most up-to-date addiction recovery models combined with state-of-the-art trauma-based treatment approaches. Ryan reported that treatment can range from 14 to 60 days of inpatient care and cost as much as \$40,000. She also noted that data in regard to the effectiveness of these rehabilitative programs are lacking.

Sexual addiction has become a multi-million-dollar industry. There are hundreds of inpatient and outpatient programs that purportedly treat sexual addiction and over 500 members of SASH who specialize in treating this condition (SASH, n.d.a). This does not include the hundreds of therapists who specialize in sexual addiction who are not members of SASH. Finally, in the last five years, a training program has been developed that certifies therapists to become sex addiction specialists ("Setting the standards," n.d.). The certification credential and the required training program were developed and spearheaded by Carnes and his associates, and the primary mode of treatment utilizes an addiction model. The development of this certification has driven a treatment model that supports the understanding of OCSB as an addictive disorder.

Another result of this conceptualization of OCSB is the development of several 12-step programs that claim to provide recovery from an addiction to sex. In the United States, these include Sexaholics Anonymous (SA), Sex Addicts Anonymous (SAA), Sexual Recovery Anonymous (SRA), Sex and Love Addicts Anonymous (SLAA), and Sexual Compulsives Anonymous (SCA). Additionally there is Co-Sex Addicts Anonymous (COSA) for the spouses

and family members of sex addicts. Data on the effectiveness of 12-step programs are not available due to the anonymity that is so integral to these programs. This perpetuates the dilemma of the belief that the behavior is a form of addiction but the lack of data to support the effectiveness of treatment based on this belief. Further, the etiology of OCSB remains a mystery and, as such, warrants further investigation.

### **Research on OCSB**

This section presents the research on OCSB. Much of this research has been published in *Sexual Addiction & Compulsion, the Journal of Treatment and Prevention*, a journal of SASH.

#### **OCSB as an Attachment Disorder**

OCSB has been related to insecure attachment styles and their impact on affect regulation (Katehakis, 2009). According to Katehakis, affect regulation is directly related to attachment issues, and these affect-regulation difficulties are, in turn, related to OCSB. Using anecdotal case reviews, Katehakis examined attachment experiences and their relation to brain function and affect regulation and saw a direct connection between OCSB and affect regulation.

Only one study to date (Zaph et al., 2008) has directly examined OCSB and attachment. This quantitative study compared scores on the SAST with those on the Experiences in Close Relationships Revised (ECR-R) scale, an attachment style assessment among a sample of 52 men recruited from two recovery websites. The results indicated that men who display OCSB tend to have an insecure attachment style. It should be noted, however, that Zaph et al. did not control for men who have been in therapy. The nature of the therapy and its duration could have had an effect on their attachment style at the time of the study (Roisman, Fortuna, & Holland, 2006). Additionally the subjects were recruited from two recovery websites so there was no clinical determination of OCSB, only self-report.

## OCSB as a Compulsion

The most vocal proponent of understanding OCSB as a compulsion is Coleman (1990). Coleman believes that the view that OCSB is an addiction is not based in science. His conceptualization concerns the defensive function of sexuality and notes that engaging in sexual behavior is used to relieve painful affect. In this sense, he sees OCSB as a function of compulsions. According to the *DSM-IV-R*, compulsions are the following:

- (1) Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
- (2) The behaviors or mental acts that are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive (APA, 2000)

Goodman (1998), however, noted problems with viewing OCSB as a compulsion. He noted that compulsions may ward off negative affects, but they do not produce pleasure, which is not the case with OCSB. Additionally, he noted that compulsions are ego-dystonic due to the distress they cause the individual, which is also not necessarily true of OCSB. OCSB, according to Goodman, is often ego-syntonic, and the behavior itself does not necessarily cause distress; rather, it is the behavior's consequences that can cause distress. Stein et al. (1992), in a study of the use of medication for individuals with OCSB, noted some important differences between individuals whose psychopharmacological intervention improved their obsessive compulsive disorder (OCD) in comparison to those whose treatment improved their depressive disorder. For patients who had OCSB and a comorbid depressive disorder, medication helped abate the symptoms of OCSB. For individuals with a comorbid diagnosis of OCD, medication improved their OCD symptoms but did not abate any of the symptoms of OCSB. This study provides

some evidence that treating OCD would not necessarily treat OCSB. Although there could be aspects of compulsion in OCSB, compulsion does not seem to be the essence of the disorder.

### **OCSB as an Addiction**

Many theoreticians and clinicians have understood OCSB as being identical to substance dependency except that the dependency is on a behavior rather than a substance. Wines (1997) studied the connection between the seven criteria in the *DSM-IV* for substance dependency and OCSB using a purposive sample of 183 men recruited through 12-step groups and a snowball sampling process. He developed a survey that assessed OCSB using the criteria of substance dependence. The criteria included increased tolerance of the behavior, withdrawal effects, unsuccessful efforts at stopping the behavior, and consequences of the behavior. The percentage of respondents who related their sexual behavior to each criterion was between 74% and 98%, which validated the relevance of these descriptors to OCSB. An important limitation was the lack of data on the validity and reliability of the instrument used in the study.

Nakken (1988) developed the concept of behavioral addictions and theorized that addiction to an activity could substitute for actual relationships. Nakken believed that the activity or the process can become the individual's primary emotional relationship due to its ability to change the way the individual feels. Nakken provides a model in which certain behaviors have affect-regulating effects. He proposed that certain individuals use activities, rather than turning to another person, as the primary method to change the way they feel. Thus, the behavior that provides the affect-regulating effects would become essential, even addictive, to the individual. Although Nakken never refers to attachment theory, his model has implications for this theory.

## **OCSB as a Symptom of Trauma**

Carnes (1983) saw OCSB as an addiction as well as believed that it was highly related to an individual's history of trauma. Carnes (1991a) developed a self-report survey, which he sent to over 1,000 individuals who were in 12-step groups for the treatment of OCSB, of whom 289 responded. Approximately 75% of his respondents reported being physically abused as a child, 80% reported being sexually abused as a child, and virtually everyone reported being emotionally abused as a child. Carnes concluded that OCSB is an addictive response to the trauma inflicted upon these individuals. He theorized that this addiction is an attempt to medicate the effects of trauma.

One aspect of trauma seen in OCSB is dissociation, and research has shown the connection between dissociation and trauma (Bliss, 1986; Briere, 1992; Gil, 1998; Herman, 1992; Kihlstrom, Glisky, & Anguilo, 1994; Kluft, 1985, 1990; Putman, 1989; van der Kolk, 1987). It was not until the mid-1990s that the connection between OCSB and dissociation was explored. Griffin-Shelly et al. (1995) used a structured clinical interview to assess dissociative disorders and then sought to determine the presence of a dissociative disorder in individuals who were identified as having OCSB. They used the Structured Clinical Interview for Dissociative Disorders, an interview process designed to identify dissociative disorders and reported to have excellent reliability and validity (Steinberg, 1993), with a sample of 21 predominantly white, middle-class, and college-educated men who self-identified as having OCSB. The results indicated that two-thirds of the sample qualified as having a dissociative disorder. The researchers theorized that the sexual behaviors were part of a dissociative response to trauma.

## **OCSB as a Psychobiological Disorder**

It is also important to understand the neurobiology of OCSB. Currently, there is no clear evidence of the biological features of OCSB; there are only theories as to what neurobiological structures may be involved. Goodman (1998) posited that, based on the available data, OCSB did not relate to androgen abnormalities and believes that OCSB seems most related to abnormalities in serotonergic function. Ragan and Martin (2000) noted that the control and regulation of sexual behavior is related to the functional domains of the hypothalamus, but they did not specify what this means in terms of OCSB. Similar to Goodman, Ragan and Martin noted the impact of the serotonergic system on OCSB. They also pointed out the effectiveness of antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), on reducing the symptoms of OCSB.

Katehakis' (2009) etiological and treatment-related model centers on attachment theory and its neurobiological impact on affect regulation. Her model takes into account misattunement and neglect as precursors to the development of vulnerability to using substances and behaviors as a way to regulate one's affect. She directs attention to the sympathetic and parasympathetic systems of the central nervous system and how they are affected by chronic misattunement. According to Katehakis, if the infant experiences chronic disengagement, his or her sympathetic system goes into fight-or-flight response. If this response is not addressed through the caretaker's attunement and comforting, soothing engagement, the child's parasympathetic system is activated as a way to protect him or her from his or her heightened affective state. Through the activation of the parasympathetic system, the child seems to be calmed; however, he or she actually is dissociated.

According to Katehakis (2009), the repetitive use of this system as a way to calm oneself can have damaging effects on neurobiological development, cognitive functioning, and the overall capacity of affect regulation. She noted the effect of misattunement and disengaged attachment patterns on the sympathetic/parasympathetic system and, in turn, on brain chemicals. She explained that the cortisol levels of the infant who is chronically neglected stay abnormally high as compared to other infants whose levels are alleviated by emotional attunement. According to Katehakis, cortisol at normal levels is helpful for self-regulation, but, at abnormally high levels, it creates a vulnerability to the chronic use of the parasympathetic strategy of dissociation. Thus, Katehakis sees OCSB as a disorder of affect regulation that is a result of insecure attachment. Katehakis views this as a disorder of auto-regulation and stated that these infants become adults who turn to themselves to regulate their affect, rather than turning to others, or what she would call co-regulation. She stated:

By better understanding the impact of early childhood attachment patterns on the neuropsychobiology of sexual addicts and their patterns, we can create a more effective model of recovery. Carne's cognitive-behavioral, task-oriented approach has enabled therapists to help patients achieve sexual sobriety. But to effect long-lasting characterological change, we believe we must access the affective right hemisphere through bodily felt states in both patient and practitioner. To repair the self, treatment must explore and mitigate the effects of early childhood trauma on emotional, cognitive, and behavioral capacities of sexual addicts and their partners. Further research into the efficacy of this protocol using instruments such as the Adult Attachment Inventory may let us broaden our recovery expectations to include genuine interpersonal connection, insight, and internally regulated affective states. (p. 28)

**Psychological behaviors related to OCSB.** To determine behavior patterns in individuals with OCSB, Lundy (1994) provided a researcher-developer Likert-type scale of OCSB behaviors to 93 professionals who were treating individuals who reported OCSB-type behavior. The results yielded 13 characteristics related to OCSB: denial and dissociation, avoidance behavior, delusional omnipotence, narcissism, obsession and compulsion, risk taking,

excessive fantasy, endangering professional/personal life, tolerating abusive relations, living a double life, desperate and irresponsible behavior, and a decline in one's spiritual life. Since the time of this study, these behaviors have often been referred to as the hallmarks of OCSB.

Giugliano (2006) conducted a qualitative study to gain a more in-depth understanding of the subjective experience and function of OCSB. Using a snowball sampling strategy, he recruited a sample of 14 men with OCSB to participate in in-depth interviews. In regard to the experience and function of OCSB, six themes emerged from the interview data: (a) meeting narcissistic needs, (b) desire for affection and connection, (c) compensation for feeling of low self-esteem, (d) avoidance of disturbing feelings, (e) re-enactments of childhood trauma, and (f) a means to cope with sexual identity.

**Subtypes of OCSB.** Some promising research and theory have come out of the work of Reid (2008, 2009, 2010, 2010a, 2010b, 2011) from UCLA. Reid's research has promoted the notion that people with OCSB are not a homogeneous group but, rather, of subtypes. In their research on the psychopathology of individuals with OCSB, Reid and Carpenter (2009) found four different subtypes of MMPI-2 profiles. They also found that, although some individuals with OCSB may have comorbid mental health diagnoses, there are many who do not. Instead, they found poor affect regulation, inadequate stress-reduction strategies, and hypomanic states present in individuals with OCSB.

Additionally, Reid, Karim, McCrory, and Carpenter (2010) challenged the long-held belief that all individuals with OCSB have impaired executive functioning (Carnes, 1983, 1991a; Goodman, 1998), which concerns the ability to adaptively interact with one's environment through use of good judgment, decision making and prioritizing, organizing, cognitive flexibility, and affect regulation. Using neuropsychological self-report measures, Reid et al.

initially found executive function impairment in men with OCSB. However, when executive functioning was assessed through actual performance on neuropsychological tests, rather than by self-report measures, it showed no differences between hypersexual and non-hypersexual individuals (Reid et al., 2011).

In a continued effort to understand the nuances of OCSB, Reid, Carpenter, Spackman, and Willes (2008) evaluated the connection between OCSB and alexithymia, emotional instability, and vulnerability to stress. They found that individuals with OCSB tend to experience difficulties in affect regulation and to show an inclination toward negative affect. Reid (2010) investigated the emotions that differentiated a sample of men in treatment for hypersexual behavior from a control group of college students. The results indicated that, among the men in treatment, self-hostility significantly predicted and perpetuated hypersexual behavior. Reid felt that this self-hostility is similar to the shame seen in men with OCSB (Carnes, 1983, 1991a) but that self-hostility affected how the individual with OCSB processes shame.

This research supports the view that people with OCSB are not a homogeneous group and that numerous nuances exist that may differentiate one individual with OCSB from another. OCSB seems to be related to different factors for different people, who also exhibit differences in the intensity of symptom manifestation. As such, OCSB needs to be understood in terms of its psychological function and how symptoms communicate certain needs.

### **Summary**

OCSB is complicated, and an understanding of its etiology and function will help with diagnosis and treatment. The common denominator to the various theories of OCSB is that there are affect-regulating difficulties in individuals who have OCSB. For this reason, attachment theory is a viable lens through which to view the development of OCSB. The connection

between attachment theory, affect regulation, and OCSB is promising, yet not well studied. Affect regulation difficulties are seen as being closely related to behavioral and process addictions such as gambling, shopping, and overworking. As will be discussed in the next chapter, various attachment patterns are attempts to solve specific problems of attachment and to experience connectedness with some degree of safety. The same could be said for the behaviors associated with OCSB. The next chapter presents the research on attachment theory, its implications for the ability to experience intimacy and relatedness, and how these implications relate to men and the etiology of OCSB.

## **CHAPTER 2**

### **ATTACHMENT THEORY**

Attachment theory was developed by the psychoanalyst Bowlby (1944), who looked at the impact of early disruptions in the lives of children. He theorized that these disruptions had an impact on children's personality development. Bowlby was strongly criticized for developing a theory that departed from the classical analytic focus on libidinal and aggressive drives (Slade, 2000). According to Slade, this criticism led to attachment theory's essentially being ignored for close to three decades, until research in neuroscience and developmental psychology led to a resurgence of the theory. Currently, attachment theory is a widely accepted model in most psychotherapeutic circles.

#### **Categories of Attachment Patterns**

Bowlby's attachment theory was expanded through work with his colleague, Mary Ainsworth, who helped to categorize the attachment experience of infants and developed what are known as the Infant Strange Situation observations (Ainsworth, Blehar, Waters, & Wall, 1978). The research of Ainsworth et al. led to the formulation of three categories of attachment patterns that relate to how infants respond to the mother's return after a separation. The three categories are secure, insecure-avoidant, and insecure-ambivalent patterns of attachment. Each category refers to a pattern of attachment that addresses attachment needs. Main and Solomon (1986), in their research using the Infant Strange Situation, added a fourth category: insecure-disorganized/disoriented. These four attachment categories result from specific types of parenting experiences and appear to be in place as early as the age of seven months (Main, 1995).

When a child has an optimal parenting experience, he or she is likely to have a *secure attachment style*. If parenting experiences are not optimal, the child could develop an *insecure attachment style*. Depending on the nature of those problematic parenting experiences, the insecure attachment style may *be insecure-ambivalent, insecure-avoidant, or insecure-disorganized*. These insecure attachment patterns will be discussed in a later section.

In a discussion of infant attachment classifications, Siegel (1999) noted that emotionally unavailable and unresponsive parenting appears to result in infants' displaying behaviors that minimize the need for proximity and connection with the returning mother, which results in an insecure-avoidant attachment pattern. He added that parenting that is inconsistently available and periodically intrusive results in children who display high levels of anxiety, inconsolability, and interminable proximity seeking upon the return of the parent. This type of parenting results in a child's developing an insecure-ambivalent attachment pattern. Finally, he explained that parents with a parenting style marked by disoriented, frightening, and/or frightened communication patterns cause their children to experience a state of dissociation and confusion, which results in an insecure-disorganized attachment pattern. Siegel noted that the parents who are available, responsive, and consistent have infants who are most often securely attached. In general, the infant attachment patterns mirrored the adult attachment patterns of their parents.

Main, Kaplan, and Cassidy (1985) felt that infant attachment categories could predict adult attachment patterns. In this regard, George, Kaplan, and Main (1985) developed the Adult Attachment Interview and engaged in research that validated this prediction. This research revealed that attachment patterns stay constant throughout one's life. This finding led to increased interest in understanding the implications of these patterns, both theoretically and clinically. Siegel (1999) believes that knowledge of attachment patterns can help to understand

the risk of psychological dysfunction and may help direct intervention strategies. He added that attachment patterns also have neurobiological implications.

### **Insecure-Avoidant Attachment Pattern**

An infant with an insecure-avoidant attachment style minimizes the need for proximity with a caretaker (Seigel, 1999). In Infant Strange Situation studies, children with this attachment style will continue to play, regardless of whether the parents return after an absence. However, below the surface of this minimizing response is an altered heart rate. Outwardly, the children seem unaffected by the proximity of their parents but experience something internally.

According to Seigel, avoidantly-attached infants:

act as if the parents never left and show no outward signs of needing the parents. At the same time, the physiological studies of avoidantly attached children and their dismissing parents clearly demonstrate that the internal value placed on attachment has remained intact and intense, however. (p. 94)

The child has a need to be consoled but it stays hidden. In this defensive pattern, the child unconsciously strategizes to keep the need hidden because he or she assumes that it will not be met.

### **Insecure-Ambivalent Attachment Pattern**

According to Siegel (1999), insecure-ambivalently-attached infants are inconsolable. The parenting style related to this attachment pattern is inconsistent, unreliable, and intrusive. He noted that, in Infant Strange Situation studies, these infants demonstrate a disturbed ability to play once their mother has returned. These children maximize their connections with the mother even though contact does not help. According to Seigel, “The ambivalently attached child has learned that his own mental state may be intruded upon by the parent in unpredictable ways” (p. 103). The child remains agitated, which actually exacerbates the need for the caretaker. In the adult with an anxious attachment, there is a constant sense that emotional needs will not be met,

which results in desperation and anxiety. The dynamic includes both a wish for closeness with the attachment figure and a fear that the attachment figure will be lost. Additionally, according to Siegel, the adult with an anxious attachment style has “leaky boundaries between past and present” (p. 105). Simply stated, the past becomes the present through distortions and self-fulfilling prophecies. The adult remains in a place of emotional longing without the ability to effectively connect, and his longing never gets satisfied. The adult’s desperation and histrionic strategy actually ward off the care that the individual so desperately needs.

### **Insecure-Disorganized Attachment Pattern**

According to Main and Solomon (1986), children with insecure-disorganized/disoriented attachment have parents whom they experience as frightening, frightened, and/or disoriented. This parenting style is connected to the failure to resolve a history of trauma in the life of the caretaker. The disorganized infant appears to experience a posttraumatic stress disorder by proxy. Main stated that these children are left with an unsolvable problem of attachment. She believes that, while the other insecure attachment styles are actually adaptive solutions to an attachment dilemma that becomes maladaptive in adulthood, the disorganized pattern lacks this adaptive quality. According to Siegel (1999), these children:

have been found to have the most difficulty later in life with emotional, social, and cognitive impairments. These children have the highest likelihood of having clinical difficulties in the future, including affect regulation problems, social difficulties, attentional problems, and dissociative symptomatology” [and are prone to] “a vulnerability to posttraumatic stress disorder. (pp. 109-111)

### **Attachment Theory and Psychiatric Diagnosis**

Main (1985) applied attachment theory to adults, noting attachment patterns are intergenerationally transmitted. In this regard, it is worthwhile to note that OCSB has often been reported to be intergenerational (Carnes, 1991a). Insecure attachment patterns have been

connected to mood disorders (Cole-Detke & Kobak, 1996; Fonagy et al., 1996; Patrick, Hobson, Castle, Howard, & Maughnan, 1994; Rosenstein & Horowitz, 1996; Tyrrell & Dozier, 1997), anxiety disorders (Fonagy et al., 1996), eating disorders (Cole-Detke & Kobak, 1996; Fonagy et al., 1996; Manassis, Bradley, Goldberg, Hood, & Swinson, 1994; Stovall-McClough & Cloitre, 2006; Zeijmans van Emmichoven, Ijzendoorn, de Ruiter, & Brosschot, 2003), substance abuse (Fonagy et al., 1996; Ward et al., 2001), and personality disorders (Babcock, Jacobsen, Gottman, & Yerington, 2000; Barone, 2003; Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Fonagy et al., 1996; Patrick et al., 1994; Rosenstein & Horowitz, 1996; Stalker & Davies, 1995; Stovall-McClough & Cloitre, 2003). Nevertheless, other than research by Zaph et al. (2008), there have not been any studies that connect OCSB and attachment styles. If attachment styles are related to mood disorders, dissociation, and personality disorders, they may provide an understanding of the underlying psychological function of OCSB.

### **Attachment Theory and Affect-Regulating Behavior**

An important aspect of attachment patterns concerns what Siegel (1999) called rupture and repair. He noted the importance of repetitious and expectable patterns of relational connection that occur between caretaker and child. These patterns allow for relational ruptures to be repaired. When there is a disruption in this process, there is a risk of insecure attachment. Siegel also noted that, in insecure-avoidant dyads, repair in ruptures do not occur, and the child is left in a state of distress and discomfort. The child learns not to seek out comfort and, instead, defends against a state of vulnerability.

In the insecure-ambivalent dyad, the repairs of rupture are inconsistent. This creates a well-reinforced interactional strategy of increasing the sense of need and simultaneously fearing the rejection, whereby there is no reliable sense of comfort. In the insecure-disorganized dyad,

the interaction with the caretaker is the source of the distress; thus, there is no repair but, rather, terror at the core of the connection. In this regard, Gianino and Tronick (1988) stated:

Infants who experience more repairs during normal interactions are more likely to solicit their mother's normal behavior when their mothers are acting in a disturbing, stressful manner (i.e., still faced). These infants, on the basis of their experience of normal interactions, have a representation of the interaction as reparable and of themselves as effective in making that repair. Infants who experience few repairs are less likely to solicit their mothers and more likely to turn away and become distressed. With the reiteration and accumulation of failure and non-reparation, the infant develops a representation of himself as ineffective and of the caretaker as unreliable. (p. 116)

These perceptions of themselves and the caretaker result in children's using self-regulating behaviors to shift their affective state instead of turning to a caretaker for comfort. This causes the child to be vulnerable to developing what Katehakis (2009) referred to as auto-regulatory and self-regulatory behaviors rather than co-regulating patterns. According to Katehakis, the children who had to rely on themselves to regulate their affect would be more at risk of developing compulsive behaviors. Katehakis related these affect-regulating strategies to a vulnerability to develop OCSB.

According to Taylor, Bagby, and Parker (1997), attachment experiences are closely tied to the function of affect regulation, and problems related to this function are connected to compulsive and addictive behaviors. Taylor et al. noted the connection between affect regulation and eating disorders, substance abuse, and other behavioral/process addictions but did not mention OCSB. Thus, further research is warranted

### **Attachment, Affect Regulation, and OCSB**

Bowlby (1969) noted that secure attachments enhance the ability to engage in the activities of play, creativity, and healthy sexual contact and that, when there is an insecure attachment, play and creativity can be impaired. Ainsworth (1991) also was interested in the interplay between attachment and exploration. According to Weiss (1998), the relationship

between insecure attachment and the impairment of play and creativity is seen in individuals with OCSB. The individual with OCSB is impaired in his ability to explore and allow for new experiences; he essentially allows his world to get smaller and smaller as he continues progressively down the road of losing control of his sexuality.

Eagle (2007) theorized that attachment patterns relate to the degree of split between desire and connectivity. He suggested that those with insecure attachments would be unlikely to integrate sexuality and attachment. In a study by Feeney and Noller (1990), university students who were classified as insecure-avoidant were found to have a tendency toward multiple relationships and a use of sex for enjoyment rather than a deepening of emotional relationships. They also had a tendency to feel *more distressed* about sexual infidelities with *less upset* about the betrayal of the emotional connection. They reported their upset to be more related to the sexual breach rather than to the emotional implications. Feeney and Noller also noted that those who were classified as insecure-ambivalently-attached tended to report frequent love experiences, to fall in love at first sight more often, and to have rapid sexual involvement. Eagle (2007) explained:

If one can say the avoidantly attached emphasize sexuality at, so to speak, the expense of attachment, one can correspondingly say that the enmeshed preoccupied emphasize attachment at the expense of sexuality. That is, their sexual behavior and experience seem to be largely in the service of repeatedly attempting to gain reassurance that they will not be abandoned. (p. 40)

This notion was confirmed in a study by Tracey, Shaver, Albino, and Cooper (2003), who found that insecurely-attached adolescents tended to use sex as a way to ward off feelings of rejection. Tracey et al. also found that insecure-avoidantly-attached adolescents had less of a tendency to connect sex with love and affection. Davis, Shaver, and Vernon (2004) found that insecurely-attached individuals tended to use sex for more manipulative, self-serving purposes

than did their securely-attached peers; and Schachner and Shaver (2004) found that insecure-avoidantly-attached individuals tended to use sexual relations for more narcissistic, self-enhancing, rather than intimacy-enhancing, motives, while anxiously-attached individuals tended to use sex to feel loved and avoid rejection. These motives have also been found to affect sexual boundary setting, indicating that insecurely attached individuals will struggle with asserting their need for safe sex practices due to fear of rejection from partners (Ciesla, Roberts, & Hewitt, 2004). Their desire for attachment interferes with their ability to advocate for protecting their health and that of their partners.

Mikulincer and Shaver (2007) believe that attachment styles result in particular experiences of sexuality. They noted that there is “evidence indicating that anxiously attached adults are vulnerable to a sexuality of despair, and avoidantly attached adults are vulnerable to melancholic sexuality” (p. 73). Mikulincer and Shaver contrasted this experience of insecurely attached adults to a “sexuality of hope” that securely attached individuals are able to experience.

Mikulincer and Shaver (2007) focused on the regulating strategies of individuals with insecure attachment patterns and found that secure attachment results in an experience of increased positive affect. They noted that those with insecure-ambivalent styles of attachment utilize anxious hyperactivation. These individuals struggle with the unfulfilled wish for attentiveness from their caretakers and amplify their emotional expression to get a hoped-for reaction from their caretakers. This results in their often feeling emotionally distressed. The researchers also noted that attempts to increase such an individual’s problem-solving ability often backfire because they thwart the anxious individual’s desire to perpetuate problematic situations as a way to induce a response from the caretaker. That the caretaker would intermittently reinforce such a strategy kept the strategy alive and well. In this sense, too much

problem-solving competence could be construed as risking loss of contact with the caretaker.

This applies to individuals with OCSB. Goodman (1998) noted the histrionic nature of many individuals who struggle with OCSB and, consequently, found that the solitary use of a treatment strategy that focuses on social skill development and problem-solving skills often does not have promising results, for the reasons noted in Mikulincer and Shaver's research.

Mikulincer and Shaver (2007) stated that those with an insecure-avoidant style of attachment have deactivating strategies, which stem from having had rejecting, dismissing caretakers. This pattern is a defense strategy that individuals use to protect themselves from the experience of constant rejection. The result is a minimization of the need for others to assist in addressing emotional issues. Bowlby (1969) stated that those with avoidant attachment patterns often develop a compulsively self-reliant manner. Bowlby also noted how those with insecure attachment styles could develop a form of compulsive caretaking. In this case, the individual always gives care, yet is resistant to receiving care. He observed that, often, these individuals find themselves attracted to those who are in great need of care. Bowlby felt that this was related to a role reversal in the child-caretaker dyad, whereby the caretaker would exert pressure on the child to act as an attachment figure, thus inverting the normal relationship. According to Bowlby, these children struggle with a high degree of anger toward the caretaker, which is inhibited in its expression, and these individuals are likely to become over-conscientious and guilt-ridden as well as insecurely attached. This inhibition results in repressed, unconscious resentment that persists into adulthood.

This pattern has relevance to OCSB. Goodman (1998) reported that many individuals with OCSB display a defensive level of autonomy and utilize sexual strategies as a way to make contact without experiencing a sense of vulnerability. He also noted that there is a tendency for

these individuals to become compulsive caretakers, and, as a result, they lack self-care. Such individuals end up feeling a high degree of resentment and deprivation, which leaves them vulnerable to acting out these feelings sexually. Both Stoller (1975) and Khan (1979) conceptualized compulsive sexual behaviors as driven by rage and hatred.

Slade (2000) spoke directly to the connection between sexuality and attachment. She noted that, as a result of insecure attachment, “sexual feelings, and indeed sexuality in general are disavowed and unintegrated aspects of functioning, and may function as split-off ways of obtaining care and or expressing aggression” (p. 1161). Slade connected Main’s (1995) notion of attachment organization with personality disturbances that may relate to specific types of sexual obsession and compulsion. Hazan, Zeifman, and Middleton (1994) also noted the impact of attachment on sexuality. They explained that individuals with secure attachment were less likely to be involved in one-night stands or sexual activity outside of a primary relationship as well as more likely to report mutual initiation and enjoyment of sexual activity. They added that those with insecure-avoidant attachment styles tended to display low levels of intimacy and less enjoyment of sexual activity. This applies to men with OCSB, who report being excessively sexual even though they experience minimal enjoyment (Langstrom & Hanson, 2006).

Bogaert and Sadava (2002) reported that women with insecure attachments display higher levels of sexual promiscuity. Gentzler and Kerns (2004) found that individuals with insecure-avoidant attachment styles tend to display higher levels of unrestricted sexual behavior and often were comfortable in sexual relationships that had minimal emotional or relational commitment. Insecure attachment also has been linked to difficulties in sexual negotiations (Feeney, Kelly, Gallois, Peterson, & Terry, 1999). These notions are similar to the formulations

of Money (1980), who saw OCSB as a symptom of a proceptive disorder, a disorder that was essentially an impairment in the ability to seek and negotiate healthy relational sexual contact.

### **Men, OCSB, and Attachment**

As noted, the majority of individuals who present with OCSB are men (Goodman, 1998). Over 30 years ago, Haviland and Maletesta (1981) looked at the differences between male and female infants and their emotional expressiveness. In their review of 12 infant studies, they found that male infants often displayed more emotional reactivity as well tended to cry and be startled more often and that their emotions changed more rapidly than did those of female infants. Olesker (1990) found that male infants show a slower achievement of emotional stability than did females, are more invested in the outside, material world, and show less inner processing. According to Levant (1997), males are more emotional in infancy; however, there is a reversal by the age of 2, which he believes occurs due to a socialization process that is supported both by parents and by society at large.

Olesker (1990) stated that boys had less awareness of maternal separation and often did not display as much clinging behavior as did girls. She noted that boys often turn to the object world to cope with their anxiety, whereas girls turn to their caretakers to help assuage their distress. According to Pollack (1998), this process continues into adulthood and leaves men more apt to cope alone rather than turn to others. He referred to this as defensive autonomy, which he believed was a result of the early emphatic separation from their maternal caretaker that left men with a continued yearning for closeness that simultaneously threatened their autonomy. This notion is in keeping with Pleck's (1981) theory of a gender-role strain that posits that, when men conform to the male role, for which the embracing of feelings are scorned, it results in a disconnection from their feelings and needs.

Fonagy, Gergely, and Target (2008) noted that the infant's ability to reflect on feelings and cognitions is directly related to the caretaker's ability to understand his or her own history with his or her own parents. Further, the ability to mentalize and reflect is directly linked to competence in affect regulation. These theories all have relevance to an understanding of the etiology of OCSB.

Goodman (1998) hypothesized that alexithymia is related to OCSB. The term *alexithymia* was developed by Sifneos (1967), who observed individuals with psychosomatic complaints and felt that the complaints were related to their difficulties in recognizing, naming, and verbalizing their feeling states. Sifneos believed that alexithymic individuals with psychosomatic complaints typically experienced their feelings as bodily states rather than as identifiable emotional states and that these individuals lost the benefit of having identifiable emotions that could be used to direct their thinking and actions. Sifneos observed that this alexithymic condition often was accompanied by impairments in self-care, object relations, empathy, and affect regulation. Goodman felt that individuals with OCSB also presented with alexithymia. He believed that these individuals often did not know what they were feeling and often experienced their feeling states in their bodies and, as such, were prone to use bodily action to address them.

Levant (1990, 1997a, 1997b) theorized that there is a normative male alexithymia. He believes that men are inclined to be alexithymic due to familial and social processes. He theorized that this male-patterned alexithymia results in an impaired ability to put feelings into words and, instead, an inclination to act out feelings. He noted that one acting-out strategy is nonrelational sex. Similar to Goodman (1998), Levant believes that men may use sex to address myriad feeling states, including sadness, fear, and anger.

More recent research indicates that biological factors, specifically testosterone, may cause male vulnerability to OCSB (Alexander & Saenz, 2010). Alexander and Saenz found that male infants with high testosterone levels showed lower levels of frustration tolerance as well as externalizing behaviors, which is often seen in OCSB (Goodman, 1998).

Testosterone appears to impact the amygdala, the region of the brain often associated with emotional reactivity. Both Ledoux (1998) and Goleman (1995) refer to the amygdala activation as “emotional hijacking,” stating that this activation can hijack an individual’s ability to be reasonable and logical. Hamann, Herman, Nolan, and Wallen (2004) found that, when presented with visual sexual stimuli, men experienced more activity in the amygdala than did women.

All these issues help to explain the speculated higher prevalence of OCSB in men. Thus, the research question that this study addressed focused on males and their attachment style as it may relate to OCSB.

### **Summary**

Attachment theory is integrally associated with affect regulation theory (Schore & Schore, 2007) and is instrumental in understanding romantic and sexual relations (Mikulincer & Shaver, 2007). Mikulincer and Shaver examined the relationship between insecure attachment and sexual behavior and noted how sexual behavior can be seen as an attempt to address the various attachment related anxieties through hyperactivating and deactivating strategies. Slade (2000) spoke to the clinical implications of insecure attachment and how it can affect sexuality. Goodman (1997), without mentioning attachment theory, explained that men’s struggle with OSCB is related to the affect regulation difficulties that they try to manage through their sexual behavior. Such research and theorizing have led to the idea that attachment and affect regulation

theories can help us to identify some of the underlying issues of OCSB, which could lead to the development of more effective treatment strategies.

## **CHAPTER 3**

### **METHODS**

This research was developed based on anecdotal observations and recent theoretical support for the notion that, at least among men, insecure attachment may be related to certain sexual strategies. Specifically, individuals with insecure attachment styles, who are more avoidant, appear to engage in a more solitary or anonymous type of sexuality with little focus on the actual connection, and those with insecure attachment styles, who are more anxious, appear to use sex to defend against the fear of being abandoned or alone (Mikulincer & Shaver, 2007). As such, insecurely attached men may be using certain sexual strategies to guarantee a reliable sense of connection.

This study investigated the relationship between OCSB and insecure-attachment styles. The research question that this study addressed is whether males who were assessed as having OCSB were more likely to be assessed as having an insecure-attachment style than men who presented without OCSB. The hypothesis was that men with an insecure-attachment style would be more likely to present with OCSB than would men with a secure-attachment style.

The results of this investigation contribute to the development of treatment approaches that address the attachment needs that underlie these behaviors. It is also hoped that the results of this study will reduce the stigma of OCSB and help individuals who struggle with OCSB to understand that they have been attempting to find a solution to their attachment issues.

The study utilized a case-control design, which allows for the one-time collection of data. The sample consisted of 77 men recruited from psychotherapists in private practice and outpatient clinics and institutes during 2012. Referring clinicians were requested to refer non-cases who presented with axis 1 diagnoses to include mood, anxiety, and adjustment disorders.

Individuals with substance addiction were excluded from the non-cases due to the anecdotal evidence that individuals with substance addiction may struggle with insecure attachment. Additionally, subjects were to be clients in the initial stage of treatment not to exceed six months in order to control for the long-term treatment effect of earned security (Roisman, Fortuna, & Holland, 2006). From an initial 81 respondents, four did not complete the assessments that measured the independent variables (ECR-S and HBI), and, thus, their data were not included. Of the 77 respondents, 45 were referred to the study as individuals who presented with out-of-control sexual behavior, and 32 presented with a condition other than out-of-control sexual behavior.

The data were derived from an assessment of OCSB as well as the level of attachment anxiety and avoidance, which then were used to determine the attachment style. This case-control design allowed for the assessment of cases in which OCSB existed as the presenting problem as compared to cases in which there is no OCSB but, rather, another presenting problem. Cases are participants who were referred to the study by licensed clinicians, with training in the assessment and treatment of OCSB, after these clinicians assessed them as presenting with symptoms of OCSB. Non-cases were participants who were referred to the study and were assessed as not presenting with symptoms of OCSB but, instead, presented with a different mental health issue. The research proposal went through the University of Pennsylvania's institutional review board (IRB). The IRB submission included the participant information form and the survey form, which included the Hypersexual Behavior Inventory and the Emotions in Close Relationships Short Form Assessment.

## **Procedure**

The majority of the referring clinicians were members of SASH, whose membership includes clinicians who are trained to assess OCSB and who work with individuals who present with OCSB. All clinicians who referred participants to the study were licensed social workers, psychologists, or psychiatrists who worked with clients who presented with a variety of mental health problems. Their evaluation of clients includes general questioning as well as the use of basic clinical assessment tools to help determine whether the person has OCSB. As part of the electronic e-mail recruitment procedure, participating clinicians were asked to determine the presence of OCSB in cases that they referred to the study. For non-cases, participating clinicians were asked to determine that the individual was someone who presented with an issue other than OCSB to include mood, anxiety and adjustment disorders and to exclude substance addiction. In determining the presence of out-of-control sexual behavior, clinicians used the proposed diagnostic criteria for hypersexual disorder, which included the identification of a consistent pattern of preoccupation with sexual thoughts, urges, and activities as a way to manage dysphoric moods and stress and of thoughts and/or behaviors that interfere with various aspects of their lives, including work, school, relationships with family and others, personal interests, and hobbies. The patients' unsuccessful attempts to stop were included as part of the diagnostic guideline, and the legal, financial, and emotional consequences of their sexual behaviors were noted.

The SASH membership is part of a national electronic mailing list (SASH, n.d.b), which was used to find referring clinicians. The director of SASH supported this research and allowed the SASH listserv to be available for this project as well as advertised the research on the SASH website. Further, outreach was conducted through workshops provided in New York City for the

New York State Society of Clinical Social Work as well as the National Association of Social Workers, in which the research design was presented, and licensed clinicians were invited to refer cases and non-cases. Finally, certain programs in New York City as well as throughout the country were contacted and asked to participate in referring participants for the study.

Case and non-case participants were directed to an online survey questionnaire by the clinician who referred them to the study. The questionnaire contained items that pertained to demographics, level of OCSB, history of adverse childhood experience, and the level of attachment anxiety and avoidance. The data were collected through the use of the web-based program SurveyMonkey.

### **Protection of Human Subjects**

Participants in the study were informed of the purpose and methods of the research by the therapist who referred them to the study. Participants also were provided with an informational form on the initial page of the survey that contained information about all aspects of the study that could have an affect on their decision to participate (Appendix A). Importantly, SurveyMonkey is structured in a manner that ensures anonymity for those who take the surveys. SurveyMonkey uses Secure Sockets Layer (SSL) encryption and multi-machine backup to keep survey data. Finally, all reporting of findings are in aggregate form only.

### **Measures**

The study used self-report measures for OCSB and attachment style. The Emotions in Close Relationships Short Form (ECR-S) was used to assess levels of attachment anxiety and avoidance and the Hypersexual Behavior Inventory (HBI) to assess OCSB. Additionally, the cases and non-cases were surveyed for the control variable of a history of abuse (physical, sexual, emotional, and neglect) through the use of the Adverse Childhood Experiences Scale

(ACE). These assessments provided data that were analyzed to determine whether individuals with OCSB were more likely to present with an insecure-attachment style (either avoidant or anxious) as compared to individuals who did not present with OCSB.

## **Attachment**

Main et al. (1985) were the first to develop assessment strategies specifically for an adult population. Their development of the Adult Attachment Interview (AAI) was groundbreaking, as it assessed issues similar to those evaluated in the Infant Strange Situation (Crowell, Fraley, & Shaver, 2008). The AAI is a semi-structured interview, used with adults, that is then transcribed and coded. Following the development of the AAI, modified forms of the interview approach to assessing attachment styles as well as self-report measures were developed. Crowell and Treboux (1995) and Crowell et al. provide an overview on the various attachment assessment tools, including their validity and reliability, that have been created over the years.

**Experiences in Close Relationships Revised (ECR-S).** The Experiences in Close Relationships-Short Form (ECR-S; Wei, et al., 2007) was utilized in this study due to its high internal reliability and good validity as well as ease of administration. The ECR-S is a 12-item, 7-point Likert-scaled self-report assessment that provides an evaluation of an individual's level of attachment anxiety or attachment avoidance. Responses can be scored as a total score that reflects the overall level of insecurity in attachment style as well as subscale scores that reflect the degree of attachment avoidance versus attachment anxiety. Each scale item requires a participant to evaluate a statement about relationships and decide where he or she falls on the range, from strongly agree to strongly disagree (Appendix B).

The scale results in data on the extent to which an individual's attachment style is secure or insecure, based on the assessment of attachment related anxiety and/or avoidance. High levels

of attachment anxiety or avoidance indicate more of an insecure attachment pattern. If there are higher levels of attachment anxiety, rather than avoidance, the individual presents with an insecure attachment but displays more distress about attachments and has *an excessive need for approval* from others. This type of individual will often present with emotional reactivity. If the individual presents with higher levels of avoidant attachment, rather than anxiety, he or she has an insecure-attachment pattern that is inclined toward defensiveness and devaluing of attachment and an *excessive need for self-reliance*. This pattern tends to result in an individual's tendency to suppress emotions and to distance him or herself from others. Low levels of attachment anxiety and avoidance indicate a secure-attachment pattern. The scale is available for use in the public domain. The scoring is as follows

Responses to questions are recorded on a 7-point Likert type scale (strongly agree to Strongly Disagree). Responses to 5 of the 12 questions are reverse-coded prior to the scoring (items 1, 3, 5, 8, and 9).

Responses to items measuring attachment anxiety (2, 4, 6, 8, 10, and 12) are averaged to create the attachment-related anxiety sub score. The higher the number, the more anxious the respondents are about relationships.

Responses to items measuring attachment avoidance (1, 3, 5, 7, 9, and 11) are averaged to create the attachment-avoidance sub score. The higher the number, the more avoidant the respondents are about relationships.

Low anxiety scores combined with low avoidance scores would indicate a secure style of attachment. (Wei, Russell, Mallinckrodt, & Vogel, 2007, p. 194)

In the present study, Cronbach's alphas were .73 for the ECR total, .77 for the ECR avoidance subscale and .76 for the ECR anxiety subscale.

## **OCSB**

The assessment of OCSB has been studied by a number of researchers (Carnes, 1989, 1991b; Coleman, Miner, Ohlerking, & Raymond, 2001; Kafka, 1994; Kalichman & Rompa, 1994; Raymond, Lloyd, Miner, & Kim, 2007; Reid et al., 2011). Lee, Ritchey, Forbey, and

Gaither (2009) stated that these assessments focus on different aspects of OCSB, including current severity, the history of the behavior and an individual's desire to manage or stop their behavior, emotional factors related to the behavior, and associated cognitions. The measure used in this study is the Hypersexual Behavior Inventory (HBI; Reid et al., 2007). The HBI has been shown to most closely reflect the proposed *DSM-V* diagnostic criteria of Hypersexual Disorder (Reid et al., 2011). Additionally, Reid et al. found that the HBI measures more of the multidimensional aspects of OCSB than do other measures.

**Hypersexual Behavior Inventory.** The HBI is a self-report measure that utilizes a 19-item 5-point Likert scale format. These items provide measurement of three domains of hypersexual behavior: (a) control over sexual thoughts, urges, and behaviors; (b) consequences of hypersexual behavior; and (c) the degree to which the individual is using sex as a way to regulate uncomfortable affects. The items on the HBI are answered based on the frequency of a thought, feeling, or behavior related to sexuality. The frequency is measured as (1) never, (2) rarely, (3) sometimes, (4) often, and (5) very often. A total score is calculated by summing responses to all items, which is then scored as follows:

If the participant scores 68 or above, the score is well above the cut-off score of 53 and falls in a clinical range where people are generally classified as having OCSB. People with high scores such as these frequently report multiple unsuccessful attempts to regulate their sexual thoughts, urges, and behaviors. They also frequently report that their sexual choices cause significant distress and various undesirable consequences in their personal lives.

If the participant scores between 53 and 67, the score is also above the cut-off score of 53. Scores such as these fall within a range that is common among individuals who seek counseling for issues related to their sexual thoughts, urges, or behavior. People with these scores often use sex to cope with various challenges in their life and/or they encounter undesirable consequences in relation to their sexuality.

If the participant scores 52 and below, the score is below the cut-off score of 53. Scores such as these fall within a range that is common among a general population and

therefore it is unlikely that their sexual thoughts, feelings, and urges create significant distress or consequences in their life. (Reid et al., 2011, pp. 50-51)

The measure has been well tested and has been shown to demonstrate high levels of validity and reliability with a Cronbach's alpha of .95 for the overall scale (Reid et al., 2011). In this present study, the Cronbach's alpha for the overall scale was .97. The measure is in the public domain and can be used in non-commercial research. It takes approximately 10 minutes to complete (Appendix C).

### **Adverse Childhood Experiences**

The effects of adverse childhood experiences can be assessed through the use of structured interviews or self-report measures (Briere & Scott, 2013). According to Briere and Scott self-report trauma assessments can assess specific symptoms of trauma, including affect regulation, interpersonal relatedness, identity problems, and dissociation. Because this study was concerned only with adverse childhood experiences as a control variable, it would have been beyond the scope to include an elaborate childhood trauma assessment, which would have compromised the practicality and efficiency of collecting online self-report data. For this reason, the measure utilized for this study, as presented below, included a simple 10-item survey that helped to identify the presence of any childhood experience that would have been considered aversive.

### **Adverse Childhood Experience (ACE) Survey.**

Experiences of childhood trauma were measured using the Adverse Childhood Experience Survey (ACE; Felitti et al., 1998), which is a measure of an individual's experience of physical, sexual, and emotional abuse; physical and emotional neglect; and household dysfunction. The evaluation of household dysfunction includes items that relate to domestic

violence, parental substance abuse, parental mental illness, divorce, and parental incarceration. Respondents are asked to provide a simple nominal measure of either 0 if there was no experience related to that type of adverse experience or 1 if there was adverse experience related to a category. The ACE results in a score between 0 and 10, with a higher number's indicating a higher level of childhood adversity. ACE results were used as a control variable (Appendix D). The ACE questionnaire is an accepted and commonly utilized scale to measure cumulative experiences of childhood adversity. Although this is a control variable, a Cronbach's alpha was calculated and demonstrated reasonable, moderate consistency for this measure (.57).

## **Demographics**

The first part of the survey gathered demographic data. These data included the participant's date of birth, ethnicity, sexual orientation, relationship status, experience of childhood trauma, substance use and length of time in psychotherapy.

## **Data Analysis**

Descriptive statistics were employed to describe both cases and non-cases in terms of demographics and study variables. Independent-group *t*-tests were performed to determine whether the two groups differed significantly on study variables, and Fischer's exact tests were used to compare groups on categorical demographic variables. Pearson correlations were conducted to assess the relationship between study variables, and regression analyses were conducted to test the hypothesis that cases and non-cases of OCSB differ in terms of attachment styles. OCSB was measured by the HBI. Linear regressions were used to examine the relationship between attachment style, adverse childhood events, and age with OCSB, as measured by the HBI. Attachment styles were measured by the ECR-S assessment.

A logistic regression analysis was conducted to predict case status (case/non-case) by attachment style, while controlling for history of abuse (ACE) and age. The regression analyses (linear and logistic) were conducted as two related models: Model 1 utilized the ECR total score, while Model 2 used ECR Avoidant and Anxiety subscales. The use of these models allowed for the determination of whether the overall measure of attachment style or the subscales are most predictive of OCSB and a better understanding of the relationship between OCSB and attachment. This analysis determined the relationship between these two variables when controlling for history of abuse (emotional, sexual, physical, or neglect) using the ACE and age. The data were analyzed using SPSS, Version 20.0.

## **CHAPTER 4**

### **FINDINGS**

This chapter presents the results of the data analysis and includes descriptive statistics and bivariate and multivariate analyses. Means and standard deviations were provided for the clinical variables, and the results of independent sample *t*-tests and the statistical assessment of the magnitude of correlations, using Cohen's (1988) conventions for correlation coefficients, are presented. Linear regressions were performed to determine whether attachment scores were predictive of a self-report of OCSB and logistic regressions were performed to determine whether attachment was predictive of a clinical determination of OCSB.

Table 1 provides an overview of the demographics of the sample, including ethnicity, relationship status, and sexual orientation. Case and non-case groups differed in ethnic composition (more cases identified as Black and more non-cases identified as Asian) but did not differ significantly in terms of sexual orientation or relationship status.

Table 1

*Ethnicity, Sexual Orientation, and Relationship Status*

	Non-Case ( <i>n</i> = 32)		Case ( <i>n</i> = 45)		<i>P</i>	Total ( <i>N</i> = 77)	
	<i>N</i>	%	<i>n</i>	%		<i>n</i>	%
Ethnicity					0.04		
Caucasian	27	84.4	39	86.7		66	85.7
Asian	3	9.4	0	0.0		3	3.9
Latino	1	3.1	2	4.4		3	3.9
Biracial	1	3.1	0	0.0		1	1.3
Black	0	0.0	4	8.9		4	5.2
Sexual Orientation					0.06		
Gay	19	59.4	16	35.6		35	45.5
Heterosexual	13	40.6	26	57.8		39	50.6
Bisexual	0	0.0	3	6.7		3	3.9
Relationship Status					0.13		
Married	23	71.9	22	48.9		45	58.4
Single	5	15.6	15	33.3		20	26.0
Cohabiting	2	6.3	2	4.4		4	5.2
Separated	1	3.1	3	6.7		4	5.2
Widowed	1	3.1	0	0.0		1	1.3
Divorced	0	0.0	3	6.7		3	3.9

Table 2 presents the means and standard deviations of scores on the HBI, ACE, ECR-Total, ECR-Anxiety, and ECR-Avoidance. The table also shows the means and standard deviations of the ages of the participants in the non-case and case groups and the total sample.

Table 2

*Means and Standard Deviations of Scale Scores and Age*

Scale	Non-Case ( $n = 32$ )		Case ( $n = 45$ )		Total ( $N = 77$ )	
	Mean	SD	Mean	SD	Mean	SD
HBI	35.81	13.143	69.47	14.681	55.48	21.770
ACE	1.87	1.755	2.60	1.763	2.30	1.785
ECR-Total	41.22	11.760	50.62	10.456	46.71	11.894
ECR-Anxiety	25.38	7.811	26.42	8.231	25.99	8.024
ECR-Avoidance	15.84	6.933	24.20	6.917	20.73	8.031
Age	41.00	10.665	44.76	11.670	43.19	11.345

As predicted, the mean HBI score of the case group was significantly higher than that of the non-case group ( $M = 69.47$  vs.  $M = 35.81$ ). The mean HBI score of the total sample is 55.48. Additionally, the mean ECR-S score was significantly higher in the case versus the non-case group ( $M = 50.62$  vs.  $M = 41.22$ ). The mean ECR avoidant score was significantly higher for the case versus the non-case group ( $M = 24.20$  vs.  $M = 15.84$ ), and the mean score for attachment anxiety also was higher for the case versus the non-case group ( $M = 26.42$  vs.  $M = 25.38$ ).

Table 3 shows the results of independent sample  $t$ -tests of the differences between scores on the scales for cases and non-cases and for age. As seen in the table, the mean HBI score of case group is 33.65 points higher than that of the non-case group. Scores on three of the scales (HBI, ECR-Total, and ECR-Avoidance) showed statistically significant differences between the case and non-case groups. There were no statistically significant differences on the ACE or in terms of age.

Table 3

*Results of t-Tests for the Scales and Age*

	Mean Difference	<i>t</i>	<i>P</i>	95% Confidence Interval	
				Lower	Upper
HBI***	33.654	-10.347	<.001	-40.134	-27.175
ACE	.725	-1.781	.079	-1.536	.086
ECR_T***	9.403	-3.619	.001	-14.598	-4.209
ECR_Anxiety	1.047	-.567	.573	-4.732	2.638
ECR_Avoid***	8.356	-5.217	<.001	-11.553	-5.159
Age	3.756	-1.464	.148	-8.871	1.360

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Table 4 shows the correlations between scale scores and their correlations with age. The magnitude of each of the correlations was assessed using Cohen's (1988) conventions for correlation coefficients, with small = 0.1, medium = 0.3, and large = 0.5. All correlations are positive. The relationship between HBI and ACE ( $r = .146$ ) is small, while the correlations between ECR-Total and ECR-Avoidance ( $r = .741$ ) and ECR-Total and ECR-Anxiety ( $r = .741$ ) are large. Additional strong relationships included those between HBI and ECR-Total ( $r = .550$ ) and between HBI and ECR-Avoidance ( $r = .589$ ). The relationship between HBI and ECR-Anxiety ( $r = .225$ ) is considered medium.

Table 4

*Correlations between Scale Scores*

	HBI	ACE	ECR_T	ECR_AnX	ECR_Avoid	Age
HBI	1	.146	.550**	.225*	.589**	.129
ACE		1	.363**	.245*	.293**	.204
ECR_T			1	.741**	.741**	.114
ECR_AnX				1	.098	.144
ECR_Avoid					1	.025
Age						1

\* $p < .05$ , \*\* $p < .01$

Linear regressions were performed to determine whether attachment scores were predictive of HBI, while controlling for history of abuse and age. As indicated in Table 5, for Model 1 (ACE, ECR-Total, and Age), the only statistically significant predictor of HBI is the ECR-Total. Specifically, a one-unit increase in ECR-Total increases the HBI score by 1.04, while controlling for other variables. For Model 2 (ACE, ECR-Anxiety, ECR-Avoidance, and Age), the only statistically significant predictor of HBI is ECR-Avoidance. Specifically, one unit of ECR-Avoidance increases the HBI score by 1.62, while controlling for other variables. These results indicate that the most important predictor of HBI is attachment avoidance.

Table 5

*Multiple Linear Regression Analysis for Scales and Age*

	Model 1				Model 2			
	<i>b</i>	<i>B</i>	SE	<i>t</i> -score	<i>B</i>	$\beta$	SE	<i>t</i> -score
ACE	-0.929	-.076	1.292	-0.720	-1.137	-0.090	1.225	-0.928
ECR_T	1.040**	0.568	0.191	5.445	-	-	-	-
ECR_An timer	-	-	-	-	0.473	0.586	0.259	1.828
ECR_Avoid	-	-	-	-	1.616**	0.174	0.261	6.189
Age	0.153	0.080	0.191	0.802	0.207	0.108	0.181	1.441
Constant	2.437		11.273	0.216	3.350		10.682	0.314

*Note.* *R*-squared for Model 1 = 0.311; *R*-squared for Model 2 = 0.391; *b* = unstandardized coefficient;  $\beta$  = standardized coefficient, \**p* < .05, \*\**p* < .01

Logistic regressions were then conducted to determine whether attachment was predictive of clinical determinations of OCSB. Table 6 presents the findings for Model 1 and Table 7, for Model 2. As seen in Table 6, the only statistically significant predictor of HSB in Model 1 (ACE, ECR-Total, and Age) is ECR-Total. A one-unit increase in ECR-Total increases the probability of being in the case group by 7.6%, controlling for the effect of other variables.

Table 6

*Binary Logistic Regression Analysis for Scales and Age: Model 1*

	Coefficient	Wald	OR	95% Confidence Interval	
				Lower	Upper
ACE	0.055	0.122	1.057	0.775	1.44
ECR_T	0.073**	7.798	1.076	1.022	1.133
ECR_An timer	-	-	-	-	-
ECR_Avoid	-	-	-	-	-
Age	0.024	1.083	1.025	0.979	1.073
Constant	-4.226	7.523	0.015		

*Note.* Nagelkerke *R*-squared = 0.225; \**p* < .05, \*\**p* < .01

Table 7 presents the findings for Model 2 (ACE, ECR-Anxiety, ECR-Avoidance, and Age). The only statistically significant predictor of HSB was ECR-Avoidance. Specifically, a one-unit increase in ECR-Avoidance increases the probability of being in the case group by 18.7%, controlling for the effect of other variables. This finding indicates that the most important predictor of HSB is ECR-Avoidance.

Table 7

*Binary Logistic Regression Analysis for Scales and Age: Model 2*

	Coefficient	Wald	OR	95% Confidence Interval	
				Lower	Upper
ACE	0.062	1.420	1.064	0.769	1.087
ECR_T	-	-	-		
ECR_Anxiety	-0.005	0.018	0.995	0.924	1.071
ECR_Avoidance	0.171**	15.035	1.187	1.088	1.294
Age	0.034	0.025	1.034	0.984	1.087
Constant	-4.533	7.267	0.011		

*Note.* Nagelkerke R-squared = 0.381; \* $p < .05$ , \*\* $p < .01$

These analyses reveal two major findings. First, individuals with higher ECR-Total scores have higher HBI scores, controlling for other factors. In particular, ECR-Avoidance has a greater effect on the HBI score than does ECR-Anxiety. Second, individuals with higher ECR-Total scores have a higher probability of being in the case group, when controlling for other factors. Again, ECR-Avoidance more strongly affects the likelihood of being in the case group than does ECR-Anxiety. The avoidance score alone is a better predictor than the total score and is much more strongly correlated with out-of-control sexual behavior than are attachment anxiety scores.

## CHAPTER 5

### DISCUSSION AND CONCLUSION

This study resulted in findings that showed the relationship of high levels of attachment anxiety and avoidance to hypersexual behavior. As hypothesized, men who were assessed as having high levels of hypersexual behavior on the HBI also were assessed as having insecure attachment based on high scores on the ECR-S. High levels of attachment anxiety and avoidance are indicators of insecure attachment. Those who display insecure attachment may tend to display a relatively even mix of attachment anxiety and avoidant behavior or may be inclined to present with one tendency more than the other. Those with more attachment anxiety tend to have an excessive need for the social approval from others as well as a tendency toward emotional reactivity and interpersonal distress. Finally, those with more attachment avoidance tend to display an excessive need for self-reliance and are more emotionally cut-off and fearful of intimacy (Mallinkodt & Wang, 2004, Mikulincer & Shaver, 2007).

Attachment avoidance is based in the defense against fears of attachment as the primary manifestation of insecure attachment. It is this defense against attachment that seems most related to OCSB. In this sense, OCSB is the manifestation of the defense. Stated differently, OCSB is the strategy that an individual uses to defend against his fears of attachment.

It is important to note the consistency of the results for the linear and logistic analyses. The linear models indicate that insecure attachment; specifically avoidant-attachment predicts OCSB based on self-report through the HBI while the logistic models show insecure attachment, specifically avoidant attachment predicts the clinical determination of OCSB. Notably, regardless of whether the presence of OCSB was based on self-report or on a clinical determination, avoidant attachment was related to OCSB. Additionally, with a sample size of n

= 72, the study had sufficient statistical power to detect medium-sized effects and provide precise estimates for the correlation and regression analyses.

### **Discussion**

This study resulted in findings that linked higher levels of attachment avoidance to a stronger predictor of hypersexual behavior than were high levels of attachment anxiety. It appears that those with high levels of attachment anxiety seek out relationships but that their constant need for reassurance and approval may leave them with high levels of interpersonal distress. Thus, those with higher levels of attachment anxiety may experience distress in their connections, but they connect, nonetheless. Individuals with higher levels of attachment avoidance may have well-developed defenses that leave them less capable and *consciously* desirous of connection. These individuals experience emotional shut-down and excessive self-reliance, yet these defenses are *not* assuaging their distress in life. Like those with high levels of attachment anxiety, individuals with attachment avoidance are often depressed, anxious, and lonely.

One strategy that those with high levels of attachment avoidance may use to address these difficulties is to sexually act out their emotional needs. These sexual behaviors may provide the opportunity for connection while disavowing the actual emotional need. This strategy creates more safety; they have the need for connection but they never have to acknowledge it. This approach is similar to what is seen in infants in Main's Infant Strange Situation experiments. The infants seem unaffected by their mothers' absence, but the heart-rate monitor tells a different story. Slade (2000) stated that, for those with avoidant styles of attachment, "sexual feelings are unintegrated and may function as split-off ways of obtaining care and/or expressing aggression" (p. 1161).

Estellon and Mouras (2012) stated that men with OCSB have difficulty trusting others and that this distrust affects their worldview. They noted that these men question whether they will have a responsive, reliable other in their lives. This also is a description of the underlying fears of individuals with an insecure attachment styles. Fonagy (2001) noted that individuals with higher levels of avoidant attachment suffer from “introjective pathology,” which he described as an intensified need for autonomous identity rather than relatedness. This parallels the idea of excessive self-reliance. He connected this type of pathology to what is seen in individuals who are schizoid, narcissistic, or antisocial. The current research, which indicates that individuals who present with higher levels of hypersexual behavior are often those with higher levels of avoidant attachment, leads to several implications.

### **Diagnostic Assessment Implications**

Slade (2000) noted the importance of understanding a patient’s attachment pattern as a means to provide effective psychotherapeutic treatment. Slade also stated that those with avoidant attachment tend to present with a character organization that is schizoid or narcissistic. The importance of understanding a patient’s attachment pattern underscores the notion that, in treating individuals with OCSB, one needs to listen closely for what is being communicated in regard to notions of attachment, counter-dependency, self-reliance, fears of intimacy, and general distress.

Masterson (1990) and Masterson and Lieberman (2004) have written extensively about the need to understand patients’ underlying character organization (schizoid, narcissistic, and borderline organization) as means to provide effective treatment. Masterson’s model takes into account the importance of determining character pathology as a means to direct the strategy of treatment (Masterson and Lieberman, 2004). This determination is particularly important, as

some theorists have noted that there are different presentations of attachment avoidance and that they should be incorporated into diagnostic and therapeutic thinking (Bartholomew, 1991).

Bartholomew's (1991) four-category model of adult attachment categorizes attachment style as being related to how an individual experiences him or herself and others. The importance of this categorization is that it can help determine the most effective treatment approach to address the underlying issues related to these attachment patterns. Bartholomew's four attachment patterns are presented in Figure 1.

	Positive View of Others	Negative View of Others
Positive View of Self	Secure Attachment	Dismissive
Negative View of Self	Preoccupied	Fearful

*Figure 1.* Bartholomew's (1991) four-category model of adult attachment.

According to Bartholomew (1991), avoidant attachment can manifest as either dismissive or fearful. If one has a positive view of him or herself but a negative view of others, that person is apt to have a dismissive, counter-dependent attachment style. If the individual has a negative view of him or herself and of others, that person is inclined to have a fearful-avoidant-attachment style. According to Bartholomew, individuals with either a dismissive or fearful style are the types of individuals who present with high levels of attachment avoidance, excessive need for self-reliance, and intense fear of intimacy. Taking the findings of the study and incorporating the ideas of Bartholomew can help clinicians to develop treatment strategies that address the patterns of avoidant behavior that underlie the behavior of the individual with OCSB.

Hypersexual men who display a dismissive style of avoidant-attachment behavior are diagnostically similar to those who present with narcissistic symptoms, while those who display fearful-avoidant-attachment behavior are similar to those who are more schizoid. Because this

research indicated that hypersexual behavior is most closely correlated to attachment-avoidance behaviors, it is important to explore models used to treat those with various presentations of avoidant attachment. According to Masterson and Lieberman (2004), these styles and their concomitant character organization require very different approaches to treatment.

### **Treatment Implications**

Slade (2000) explained that those who present with avoidant-attachment behaviors have a tendency to be narcissistic or schizoid. Masterson (1990) and Masterson and Lieberman (2004) believe that an individual who presents with narcissism needs a very different approach than what is needed for someone who presents as schizoid. In the case of narcissism, Masterson, and Masterson and Lieberman stated that the treatment requires the therapist to provide a mirroring response to the narcissistic vulnerability and the pain experienced by the patient, while also noting the defensive manner in which the patient wards off this pain. An example of such a patient is a hypersexual man whose need for control and power results in his being more apt to engage in sexual behaviors that involve the use of commercial sexual activity (e.g., prostitution, sexual massage). This type of hypersexual patient also may be inclined to narcissistically compensate for his sense of inner defect and emptiness through maintaining multiple affairs. For the patient with OCSB, this would require framing the sexual acting-out behaviors as a defensive strategy that responds to some type of narcissistic injury or vulnerability.

Masterson and Klein (1995) stated that the schizoid patient would need help to see and understand his fearful experience of relationships and how he always works to modulate distance due to worries of getting too close to or too far apart from others. For this type of patient, closeness brings with it the risk of appropriation and/or aggression, while distance results in a sense of desolation and complete disconnection. According to Masterson and Klein, it is

essential to identify this schizoid dilemma so that the patient can see how he operates out of the simultaneous yearning for and defense against attachment. This type of hypersexual patient may be more inclined toward sexual fantasy facilitated by virtual modalities, including pornography, Internet chatting, video cams, voyeurism, and other more distant ways of imagining a connection. These patients yearn to engage but only from afar.

Combining Bartholomew’s (1991) attachment model with Masterson’s (Masterson, 1990; Masterson & Lieberman, 2004) characterological model of treatment results in the grid presented in Figure 2.

	Positive View of Others	Negative View of Others
Positive View of Self	Secure Attachment	Attachment Pattern: Avoidant Dismissive Character Pattern: Narcissistic
Negative View of Self	Attachment Pattern: Preoccupied Character Pattern: Borderline	Attachment Pattern: Avoidant Fearful Character Pattern: Schizoid

*Figure 2.* Composite of Bartholomew’s (1991) and Masterson’s (Masterson, 1990; Masterson & Lieberman, 2004) models.

Crocker and Lathrop (2007, 2008) took the Masterson (Masterson, 1990; Masterson & Lieberman, 2004) treatment model of personality disorders and applied it to individuals with OCSB as a means to specify the underlying disorder. Building on this model, Crocker and Aaron (2012) brought in Bartholomew’s (1991) and Masterson’s (Masterson, 1990; Masterson & Lieberman, 2004) models and proposed a model that incorporates the various hypersexual behaviors that may relate to specific attachment and character patterns, as seen in Figure 3.

Hypersexual Behavior	Character Organization	Childhood Attachment	Adult Attachment
Commercial sex and multiple affairs	Narcissistic	Avoidant	Dismissive
Pornography, Internet chatting, video cams, voyeurism	Schizoid	Avoidant	Fearful
Romantic obsessive, engaging with an emotionally limited or unavailable partner	Borderline	Anxious	Preoccupied

Figure 3. Crocker and Aaron's (2012) model.

### General Theoretical and Treatment Ideas

In addition to a focused treatment model for avoidant-insecure behavior that has manifested as OCSB, there are some general theoretical and treatment ideas for insecure attachment that come from the attachment literature. Fonagy's (2001) attachment-oriented model of treatment includes the goal of increasing a patient's reflective function and understanding of his narrative as a means to increasing his sense of secure attachment. Ogden (1989) noted the need for the patient to develop a historical consciousness. He believes that psychological growth requires a need to connect experiences of the past with those of the present, along with the hope for the future. Ogden believes that, for change to occur, the patient needs to have a sense of historicity. This is in keeping with Fonagy's positing that the patient needs to understand his own narrative, which is an aspect of an enhanced ability for reflective function. Fonagy believes that reflective function allows for a sense of subjectivity and

unfreezes temporality, which enables the patient to develop a sense of continuity and connection with others.

According to Estellon and Mouras (2012), individuals with hypersexual behavior lack this reflective function and do not have a sense of their own historicity or another's subjectivity. This deeply affects how they experience life. In this regard, they stated:

Believing requires recognition of not only the power of invisible phenomena but also hope. Some of the beliefs are vital: belief in the natural functioning of one's own body; in the continuity of self; in the reality of the outside world; in the consciousness of others. Without that, it will be difficult to inhabit one's own life. And as Freud reminds us, to love other people, one must first be able to love oneself. Subject to narcissistic fragilities and affective deficiencies that he in general would rather ignore, the sex addict uses other people's bodies for a fix and to forget that he no longer believes in anything much, including himself. (p. 3)

Considering these ideas, treatment should include enhancing the individual's sense of historicity through helping them to expand on their narrative and understand their past as it relates to the present. Additionally, helping patients to move beyond their primary sense of self towards their sense of other becomes essential to address their lack of another's subjectivity.

Schore and Schore (2007) believe that attachment theory is inseparable from affect regulation theory. They proposed that psychoanalytic models are necessary for the development of effective treatment of the deeper-seated affect regulatory issues found in attachment disorders. They stated, "Modern attachment theory is thus a regulation theory consonant with the current relational intersubjective trends in the psychodynamic literature, and thus can be readily incorporated into the core of social work theory, research and practice" (p. 2). They integrated attachment research with neuropsychological findings that indicate that attachment patterns are affectively imprinted into our right brains, as these patterns are set early in our development at a time in which the right brain predominates. They also explained, "Attachment experiences are thus imprinted in an internal working model that encodes strategies of affect regulation that act at

implicit nonconscious levels” (p. 4). They noted that these imprints occur due to the dyadic experience between mother and child and that they are a result of right-brain-laden intersubjective connections. This leads to the idea that treatment that is designed to address attachment related patterns must address the preverbal experience.

Wallin (2007), like Schore and Schore (2007), noted that preverbal experience comprises the core of the developing self and that this experience results in the various attachment patterns of our patients. With this in mind, they see treatment as needing to address the non-verbal material that is presented in psychotherapy, whether it is body language, facial expressions, or enactments. Considering the findings of our research, which connect hypersexual behavior to insecure attachment, Wallin’s recommendation is apt. Wallin (2012) stated:

just as the original attachment relationship(s) enabled the child to develop, it is ultimately the new relationship of attachment with the therapist that allows the patient to change. In generating a secure base, we help patients to deconstruct the attachment patterns of the past, to construct new ones in the present—and to integrate previously dissociated experience (p. 3).

It is this work that can transform an insecurely attached adult into an adult with a sense of “earned security” (Wallin, 2012).

### **Clinical Social Work Implications**

As noted by Schore and Schore (2007), modern attachment theory is integrally related to social work philosophy and ideology. They posit that attachment theory is essentially a biopsychosocial model stating “individual development arises out of the relationship between brain/mind/body of both infant and caregiver held within a culture and environment that supports or threatens it” (p.2). Slade (2000) highlights the importance of the therapist’s awareness of his or her attachment style and how such styles interact with the attachment style of the patient. She notes that increased awareness of this interactive dynamic can facilitate the development of the

therapeutic alliance. Clinical social work theory diligently focuses on the importance of developing a therapeutic alliance in order to assist clients in making change in their lives and enhancing the quality of their relational world (Norcross, 2011). The results of this study clearly indicate that those with OCSB struggle with difficult attachment styles that can often leave them alienated and perceived as difficult to treat. Difficulties like these can leave suffering people and their families either untreated or treated ineffectively. This results in future families inheriting untreated attachment issues as well as becoming vulnerable to the development of addictive behaviors. The increased understanding that this study offers can help to contribute to making change in these intergenerational struggles. Individuals and families can be better helped to attach, connect and love.

### **Study Limitations**

The study was correlational, and this type of research design cannot determine causal relationships between variables. It is possible that OCSB is not only a symptom of insecure attachment but also may be a set of behaviors that cause and maintain a level of insecurity in the attachment styles of the subjects. Additionally, the participants were predominantly Caucasian, which limits the generalization to other ethnicities. Further, although the participants in both groups were primarily Caucasian, there were more cases identified as Black and more non-cases identified as Asian. This does not, however, limit the veracity of the analysis, as ethnicity was not a variable of interest.

The study also depended on clinicians who referred participants to the online survey. There was no control over the diagnostic training of the referring clinicians, even though the clinicians were known to have an expertise in working with individuals with OCSB, and we used the diagnostic criteria of the proposed Hypersexual Disorder diagnosis. The study did not

provide administrative oversight of the use of the diagnostic criteria, and, as such, we had to assume that clinicians used the diagnostic criteria in the way that was intended. Finally, this study has the inherent limitations related to the use of self-report measures, including the social desirable, acquiescent, and extreme responding (Paulhus & Vazire, 2007).

### **Future Research**

Future research should extend the findings of this study by using a larger and more diverse sample. Additionally, it would be valuable to design a study that enables a determination of whether certain sexual behaviors are related to certain types of insecure attachment. As noted, there are different types of avoidant-attachment styles, and it would be important to determine whether specific avoidant styles match the specific sexual behaviors as noted in Crocker and Aaron's (2012) model. All such research would be in the service of developing effective treatment methods.

## APPENDIX A

### RESEARCH INFORMATION FORM

#### Attachment Style as it Relates to Out of Control Sexual Behavior

**The following provides information in regard the study and what is being requested from you in your participation. Please feel free to ask your therapists any questions that you may have as he/she has been thoroughly informed as to the purpose and the methods of the study. Thank you for participating.**

#### Introduction and Purpose of Study

I am a doctoral student at the University of Pennsylvania studying the connection between the way someone is able to attach and connect in a relationship and the level of frequency and intensity of their sexual behavior.

#### What is involved?

The survey that I am asking you to complete is on the Internet and is provided by SurveyMonkey. SurveyMonkey is a website design that is structured to ensure your privacy and anonymity. Your identity does not need to be revealed. The first part of the survey provides general questions about your background and behavior. The second part is about your behavior, thoughts, and feelings related to sexuality, and the third part is about your thoughts and feelings related to relationships and intimacy. The survey will take about 30 minutes to complete.

#### Anonymity

Based on the web design of SurveyMonkey, the providing of your identity will not be necessary to complete the survey. This will allow your involvement in this study to remain anonymous. To participate in the research, your therapist will give you an ID number that you will use in completing the survey.

#### Risks of Participating

The risks of participating are minimal. As noted, your participation in the survey is anonymous. In the unlikely event that you find the questions in this survey upsetting, you can decide not to participate. At that time, you can speak with the therapist who referred you to this project to get the necessary support that you may need.

#### Benefits of Participating

Although answering these surveys will not necessarily help you directly, it is possible that you will find these survey questions thought provoking and interesting. The benefits of the study are that the results will contribute to the understanding of why people have differing levels of sexual behavior and how that may relate to their experience of attachment and intimacy.

## APPENDIX B

### EXPERIENCES IN CLOSE RELATIONSHIPS-REVISED (ECR-S)

Fraley, Waller, and Brennan (2000)

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you *generally* experience relationships, not just in what is happening in a current relationship. Respond to each statement by circling the number to indicate how much you agree or disagree with the statement

1            2            3            4            5            6            7

Strong Disagree

Strongly Agree

1. It helps to turn to my romantic partner in times of need.
2. I need a lot of reassurance that I am loved by my partner.
3. I want to get close to my partner, but I keep pulling back.
4. I find that my partner(s) don't want to get as close as I would like.
5. I turn to my partner for many things, including comfort and reassurance.
6. My desire to be very close sometimes scares people away.
7. I try to avoid getting too close to my partner.
8. I do not often worry about being abandoned.
9. I usually discuss my problems and concerns with my partner.
10. I get frustrated if romantic partners are not available when I need them.
11. I am nervous when partners get too close to me.
12. I worry that romantic partners won't care about me as much as I care about them.

## APPENDIX C

### HYPERSEXUAL BEHAVIOR INVENTORY (HBI)

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Below are a number of statements that describe various thoughts, feelings, and behaviors. As you answer each question, choose the answer to the right that best describes you. Please be sure to answer every question.

For the purpose of this questionnaire, sex is defined as any activity or behavior that stimulates or arouses a person with the intent to produce an orgasm or sexual pleasure. Sexual behaviors may or may not involve a partner. (e.g., self-masturbation or solo-sex, using pornography, intercourse with a partner, oral sex, anal sex)

Response options are: (1) never, (2) rarely, (3) sometimes, (4) often and (5) very often.

1. I use sex to forget about the worries of daily life.

2. Even though I promised myself I would not repeat a sexual behavior, I find myself returning to it over and over again.

3. Doing something sexual helps me feel less lonely.

4. I engage in sexual activities that I know I will later regret.

5. I sacrifice things I really want in life in order to be sexual.

6. I turn to sexual activities when I experience unpleasant feelings (e.g. frustration, sadness, anger).

7. My attempts to change my sexual behavior fail.

8. When I feel restless, I turn to sex in order to soothe myself.

- |  |                      |
|--|----------------------|
| 9. My sexual thoughts and fantasies distract me from accomplishing important tasks.          | <input type="text"/> |
| 10. I do things sexually that are against my values and beliefs.                             | <input type="text"/> |
| 11. Even though my sexual behavior is irresponsible or reckless I find it difficult to stop. | <input type="text"/> |
| 12. I feel like my sexual behavior is taking me in a direction I don't want to go.           | <input type="text"/> |
| 13. Doing something sexual helps me cope with stress.  | <input type="text"/> |
| 14. My sexual behavior controls my life.   | <input type="text"/> |
| 15. My sexual cravings and desires feel stronger than my self-discipline.                    | <input type="text"/> |
| 16. Sex provides a way for me to deal with emotional pain I feel.                            | <input type="text"/> |
| 17. Sexually, I behave in ways I think are wrong.  | <input type="text"/> |
| 18. I use sex as a way to try and help myself deal with my problems.                         | <input type="text"/> |
| 19. My sexual activities interfere with aspects of my life such as work or school.           | <input type="text"/> |

**APPENDIX D**

**ADVERSE CHILDHOOD EXPERIENCES SURVEY**

**(Felitti et al., 1988)**

1. Did a parent or other adult in the household **often or very often** swear at you, insult you, put you down, or humiliate you? **Or** act in a way that made you afraid that you might be physically hurt? (Yes) (No)

If yes enter 1 \_\_\_\_\_

2. Did a parent or other adult in the household **often or very often** push, grab, slap, or throw something at you? **Or ever** hit you so hard that you had marks or were injured? (Yes) (No)

If yes enter 1 \_\_\_\_\_

3. Did an adult or person at least 5 years older than you **ever** touch or fondle you or have you touch their body in a sexual way? **Or** attempt or actually have oral, anal, or vaginal intercourse with you? (Yes) (No)

If yes enter 1 \_\_\_\_\_

4. Did you **often or very often** feel that no one in your family loved you or thought you were important or special? **Or** your family didn't look out for each other, feel close to each other, or support each other? (Yes) (No)

If yes enter 1 \_\_\_\_\_

5. Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** your parents were too drunk or high to take care of you or take you to the doctor if you needed it? (Yes) (No)

If yes enter 1 \_\_\_\_\_

6. Were your parents **ever** separated or divorced? (Yes) (No)

If yes enter 1 \_\_\_\_\_

7. Was your mother or stepmother **often or very often** pushed, grabbed, slapped, or had something thrown at her? **Or sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **Or ever** repeatedly hit at least a few minutes or threatened with a gun or knife? (Yes) (No)

If yes enter 1 \_\_\_\_\_

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? (Yes) (No)

If yes enter 1 \_\_\_\_\_

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? (Yes) (No)

If yes enter 1 \_\_\_\_\_

10. Did a household member go to prison? (Yes) (No)

If yes enter 1 \_\_\_\_\_

**Now add up your “Yes” answers:** \_\_\_\_\_  
**This is your ACE Score.**

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