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# Sexual Compulsivity and Gestalt Therapy: A Case Study

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## Introduction

Not until the late 1980s did education programs, workshops, and clinics surface to educate therapists in sexual compulsivity (Schneider, 2004). Currently *The Society of the Advancement of Sexual Health* (SASH), founded in 1987, holds an annual conference to enable networking and education on the latest trends. Acceptance for sexual compulsivity treatment received another boost with the development of the *Sexual Addiction & Compulsivity* journal. While this journal provides specific attention towards treatment and recovery, no clear unifying consensus has emerged as a theoretical base among clinicians. Many manuscripts found within the journal focus on sexual addiction in conjunction with another diagnosis such as depression, stress, gambling, drug use, ADHD, and Asperger's.

Beyond focusing on sexual addictions in terms of comorbidity, authors have focused on specific interventions such as motivational interviews, eye movement desensitization and reprocessing (EMDR), and experiential exercises. Consistently these articles call for more research, research focused specifically on sexual addiction and compulsivity, and a well defined multi-modal theory to ground service providers in theoretical consistency. In fact, the lack of consistency prompted Hagedorn (2009) to conduct a study to identify competencies vital to successful treatment, which highlighted skills in assessment and diagnosis. It could be argued that the lack of educational training programs that ensure competencies in treating sexual addiction or compulsivity contributes to the paucity of linear research focused on finding a proven theoretical lens to guide treatment.

A theoretical lens, or rather a theoretical orientation, is vital for a clinician to establish for themselves to ensure consistency in treatment and a strategic method of treatment. It is typical for specific theories to be identified as predominately successful with specific diagnoses. As of yet, no theory has been identified as the predominant match for clients working through sexual addiction or compulsivity. This paper is

designed to reintroduce and reinforce Friedman's (1999) encouragement of Gestalt Therapy as the perfect fit for treating sexual addiction. It is warranted to review his assertion considering that 11 years have passed, there has been an expansion of client need, and there is a mere 17 years total since sexual compulsivity first gained attention. First, a client case study will be shared as a vehicle to frame the usefulness of Gestalt's tenets as a match for conceptualizing sexual compulsivity.

### **"Jane"**

What struck me most when Jane first walked into the office with the intake paperwork already filled out and rolled up tightly in her left hand was the absence of the usual anxiety and hesitancy of a first time client. She was a woman on a mission. A task had been presented to her and she was determined to complete it, a strange determination without confidence or fear. From the referral call a few weeks prior, I already knew why she was here. If she wanted to reclaim her three children from the foster care system, she would have to participate in individual counseling, something she had never before done in her brief 23 years. I began to wonder if her lack of anxiety was due to the fact that she didn't know what to expect—how difficult the change process could be. But as we went over the informed consent, there emerged an overwhelming sense of resigned apathy. She was compliant and answered any and all questions without reservation or hesitancy. Her life was an open book that she narrated from a distance. Page by page she told Jane's story matter-of-factly.

Jane grew up in a small western town with her mother. Dad was a man without a name or a face. There was a long string of visiting and live-in boyfriends that came and went along with half brothers and sisters whose existences were just as fleeting. The true constants in her life were mom and mom's preoccupation with anything other than Jane. She often found herself alone throughout grade school. She had difficulty making or keeping friends. Jane had a freedom that her peers just couldn't relate to or keep up with. She spent the empty hours of the day wandering the small town streets without sidewalks, walking the solid white line on the shoulder of the road as families in minivans slowed down and navigated around her. By the time she turned 11 years old the older neighborhood boys began to notice and welcome her. The boys talked of sex, telling stories they'd heard and describing their exploits in naïve detail. Among her new group of friends Jane alone had no stories to tell. She had nowhere else to go, nothing else to fill her time or isolation. She listened to the boys' banter without interest, but they found her innocence more than interesting.

One day, not quite yet 12, the banter circled her virginity and all she was missing. The boys insisted that she simply had to try it, to experience what she was missing. Jane knew what the boys wanted and she followed the more vocal one into the house while the others laughed in gasps and awes and punched each other in the shoulder. She finished this surprisingly well rehearsed and disconnected story by adding, "So afterwards I went home... Whatever, that's what boys want. It's just the way it is. Why not, it's all they want." Her voice was vacant and her stare short and nondirective. No, she didn't tell her mom or anyone else, why would she. No, she didn't think about it much afterwards. Yeah, it is just one of those things that happen growing up, everybody does it eventually.

The incident initiated a new but familiar direction in her life. Without much cajoling by the boys she made her way through the group. Some lasted longer than others, but none stuck around. She eventually began to augment these encounters with the older neighborhood boys with a secondary option for mom's long line of ambivalent suitors. Finding no one home more often, Jane began spending more nights around town with whoever would put her up for a night or two. She paid her own way through sex and odd jobs. She would meet random men around town and they would take her home. Some were nice and some weren't, but it didn't really matter anyway. By her second year in high school, she stopped going home at all and lived from one house and sexual favor to the next. Inevitably it wasn't long before she was pregnant and dropped out of school. Shortly after giving birth, she met a guy at the gas station on his way through town. She stayed with him in his car for a couple of weeks before he invited her and the newborn to go with him to Nevada. With nothing to keep her in the small town, she buckled herself in for the trip.

Remembering back to that long drive through the desert, Jane recalled fantasizing about their life together. No white picket fences. No evenings by the fire while the long haired golden retriever slept at their feet. But he must have had a plan, a job waiting for him, something. Of course he was going to take care of them, maybe they could even be a family. But what awaited the young traveler and her baby was the same as what she left behind, nothing. The fact that he had no job waiting for him became apparent when they got across the border into Nevada and moved into a homeless shelter. The money they had didn't last long as the man she almost hoped would take care of them, spent all that was left on drugs and alcohol. They were running out of options, but it turned out he did have a plan after all. Within walking distance of the shelter was a truck stop brothel, a group of mismatched trailers behind an old run down diner with blackened windows and an oversized gravel parking lot forever full of eighteen wheelers. He told her it was time to go to work and the baby would stay with him. She didn't argue. She walked down the white line on the edge of the two lane highway.

Jane's new occupation required her to "work the pole" while she waited for the next paying customer. Barely clothed, she would circle the room or stand in the "lineup" enticing the truckers to spend whatever money they had on her. She would do anything they asked from her as long as they paid. The only thing she objected to was being urinated on, but even that she would consent to, "if they paid for it." Unfortunately the money wasn't as good as her new boyfriend wanted it to be and soon he was gone too. Six months after leaving the small town she packed up the baby again and headed back to nothing in particular, just back to where it all started. The old routines came back quickly, as well as two more kids. But roaming from house to house with three kids in tow wasn't quite as invisible as it was before and an anonymous call was made to family services.

Unshakable, she sat across from me in a pair of jeans and an oversized hooded sweatshirt telling Jane's story, only pausing for breath. What was done is done and she was ready to move on to more current issues. She finally had a steady job waitressing and an apartment of her own. She was drug tested regularly by the court and had been clean and sober for several months in a row. Her new boyfriend wasn't restricted and spent much of his spare time in the local bar. Finding herself alone again, her mind began to wander to what he might be doing without her. She knew from a young age what all men wanted and she was consumed by a new emotion, jealousy. If she had to be in counseling

anyway, that is what she wanted to change. The jealousy was too much for her and she wanted it to go away, but even this unrelenting emotion was lost in the rock like features of her face.

### **Defining the Problem**

Jane's story is not unique and most clinicians have had similarly disconnected stories of sexual compulsivity related to them. The names and details change with the uniqueness of each client, but much is still shared among them. How to treat these complex and daunting individuals is often difficult for even the most seasoned clinician. Prior to 1983 and the publication of Patrick Carnes' controversial book entitled *The Sexual Addiction*, which was later changed to *Out of the Shadows* to alleviate some of the resistance in the field, sexual compulsivity was not even on the clinical radar. In Kingston and Firestone's (2008) literature review of conceptualization and diagnosis of problematic hypersexuality, they found an emergence of a general agreement among researchers and theorists concerning the essential features of sexual compulsivity. They reported that the most prominent concept is that sexual compulsivity is the difficulty to regulate sexual impulses in spite of negative consequences. Based upon this definition, it only makes sense that a treatment modality to address the necessary client awareness and skill set to regulate their impulses be adopted. However, there is still a glaring reality that no unified agreement on treatment has been made amongst professionals in the field. Without proper and accurate diagnosis and treatment clients will miss the opportunity to work through and gain awareness of the destructive pattern (Adams, 2002).

From the absence of a unified theory, two competing but incomplete umbrellas of thought have risen to the top; sexual science and addictionology (Adams, 1999, 2002; Carnes, 1983; Creedon, 2004; Kingston & Firestone, 2008). Neither uses therapy with the benefit of a comprehensive theory on sexual compulsivity. Models of sexual science tend to focus on low sexual desire and only touch on hypersexuality (Leiblum & Rosen, 1988, 1989; Rosen & Leiblum, 1995; Simons & Carey, 2001). On the other hand, addictionologists, who explain hypersexuality through addiction, compulsivity, and impulse control, offer models heavy on sexual desire foci (Leedes, 2001; Reid, Carpenter, & Lloyd, 2009).

Addiction models are also criticized because there is continued resistance to fully accept Carnes' (1983) introduction of behavior as addiction. While some assert that sexual addiction and compulsivity is a behavior issue, others contend it is primarily psychological (Carnes, 1983; Leedes, 2001). Furthermore, there is debate about whether sexual compulsivity is an obsessive-control disorder (OCD) or an impulse-control disorder (Kaftka, 2007). Leedes (2001) presents the belief that there are obsessive compulsive implications for treatment of sexual addictions and possibly diagnoses. His point is that to focus primarily on behavior without a keen appreciation of the obsessive inner world is to ignore the motivation of the compulsive behavior which may or may not be present.

Compulsive behavior consideration in sexual compulsivity may gain more interest if the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* begins to include criteria for diagnoses. However, followers of the psychological approach in conceptualizing sexual addiction and compulsivity tend to use

Bowlby's (1988) attachment theory. In fact, a recent journal article search in a commonly used academic search engine found over 600 responses connecting attachment theory with sexual compulsivity just from the last two years (2008-2010). In application, attachment theory views that when a "trauma," in some form, occurs while a child is forming close attachments, they are impelled to compensate, often in maladaptive behaviors (Bowlby, 1988). Research endorses the connection between attachment formation and sexual addiction as 95% of identified sexual addicts are unable to form close attachments with others rooting from childhood issues (Leedes, 2001) a finding supported in a similar study conducted by Zapf, Greiner and Carroll in 2008. In fact, the one commonality among frameworks is that sexual compulsivity is an issue that stems from early years in an individual's development (Adams, 1999; Adams & Robinson, 2001; Creeden, 2004; Perera, Reece, Monahan, Billingham & Finn, 2009; Schwartz & Southern, 1999). This can be seen in Jane's story as well, a childhood characterized by an absence of connectedness with adults or peers and early sexualization.

Child abuse and neglect are common factors in the histories of individuals who manifest hypo/hyper sexuality (Schwartz, 1996). It is believed that an overwhelming experience during childhood leads to an inability of the individual to assimilate in society (Schwartz & Southern, 1999). Acting out sexually is an expression of suppressed affect related to past injustice in childhood which simultaneously reduces anxiety and causes the individual to feel exhilarated (Main & Solomon, 1995). Without the ability to create an understanding for the events, emotions become constricted and the "self" becomes the focus. An increase in this specific tension causes a high selectivity in perception (Sherrill, 1986).

As adults, an internal conflict emerges leading individuals to desire a release of this tension (Adams & Robinson, 2001). Humans are creatures of habit whom often adopt routine when facing a perceived issue; for some, this comes in the form of sexual compulsivity. This compulsion may then begin to emerge as an addiction (Adams, 2002). In other words, this form of release becomes the only understood way to resolve the chaos felt internally. Engaging in the perceived object of relief is a means of internal regulation and calming (Raymond, Coleman, & Miner, 2003; Schwartz & Southern, 1999). Sexual behavior, or simply the preoccupation and rituals that precede it, is used as a "fix" to relieve psychological pain (Friedman, 1999; Raymond et al., 2003).

Sexual compulsivity is about achieving mood alteration (Carnes, 1983; Kingston & Firestone, 2008; Schwartz & Abramowitz, 2003). The individual also creates self-functions, which are tools to negotiate interactions with others, manage the intensity of the experience, and balance inner and outer experiences (Griffin-Shelley, Benjamin, & Benjamin, 1995, Leiblum & Rosen, 1988, Main & Solomon, 1995). Self functions navigate the balance between old and new experiences by moderating intense feelings (Schwartz & Abramowitz, 2003; Schwartz & Southern, 1999).

The intensity of feeling tends to climax until the defense mechanism of the individual creates a disconnection and blocks the awareness of internal realities (Schwartz, 1996). It could be argued then that the unresolved issues that underlie these emotions must be worked through and integrated back into the self. Healing then should come from the reverse of the persons unraveling; connection and awareness (Friedman, 1999). Insight can be found in re-organizing one's cognitions through awareness to

relieve the internal stress and thereby solving the problem (Herwig, Kaffenberger, Jäncke, & Brühl, 2010; Sherrill, 1986).

The capacity for bonding with others is critical for human survival and well-being (Bowlby, 1988; Schwartz & Southern, 1999). However, individuals that have an internal disconnection face troubled relationships due to their tendency to become only an extension of their partner's identity and their boundaries become blurred (Schwartz & Southern, 1999). Absorption of the other person's ego into the self leaves the individual dependent upon the other for survival. It becomes difficult to see where they end and their partner begins. This was true for Jane even though she did not initially recognize it. She often talked of sex as a function she performed for her partners without desire or joy on her part. Her needs were blurred and overshadowed by those of her partners. The fact that she could want something outside of what the men wanted was beyond her reasoning.

When there is no autonomy, a separated sense of "I" and "we", dysfunctional intimacy disorders emerge (Bowlby, 1988; Schwartz & Southern, 1999). Real persons cannot live up to the idealistic imaginings in virtual reality that a sexually compulsive person is seeking. They yearn for close attachments, but their expectant models prevent any form of sustained intimacy (Griffin-Shelley et al., 1995; Leedes, 2001; Leiblum & Rosen, 1988, 1989; Schore, 2001; Schwartz, 1996). Sexual addicts compensate for their inability to form close attachments by fantasizing about unattainable and unrealistic surrogates (Leedes, 2001; Schore, 2001; Schwartz, 1996; Zapf, Greiner, & Carroll, 2008).

Without the ability to assimilate or integrate, the individual experiences identity as many "selves" or feels like an imposter due to inherent experience of contradiction (Goodman, 1993; Griffin-Shelley et al., 1995; Leiblum & Rosen, 1988, Main & Solomon, 1995; Zapf et al., 2008). One self is seeking the perfect relationship while the other is engaging in sexual acts to release tension. Each of these "selves" has the capacity to produce behavior and has impulses for action (Leiblum & Rosen, 1988, Main & Solomon, 1995, Zapf et al., 2008). One system can be cut off from another, leading to unconscious motives for behavior (Leedes, 2001). When there is extreme internal encapsulation, a person can act with seeming integrity and have multiple partners while not actually experiencing conflict or the implied contradiction (Leedes, 2001). The mechanism of dissociation allows for the apparent anomaly in which "good people do bad things" (Schwartz & Southern, 1999).

## **Treatment**

As mentioned earlier, it is necessary for treatment modalities to be congruent with the working definition of sexual compulsivity, specifically, the ability to assist clients in awareness attainment and skill development in regulating impulses. It would seem logical that the attainment of awareness would be based in the beliefs that sexual compulsivity is rooted in childhood experiences that hinder the ability to forge intimacy with others, which causes tension and anxiety that result in the sexual indiscretion cycles for relief. In addition, the skill sets required would involve treatment that includes awareness, as well as, strategies for the emotional regulation connected to the tensions and anxiety. Hence, the aspects of awareness and skill could not be separate constructs but interwoven ones.

The current trends in sexual compulsivity treatment, however, have been specific to pre-existing non-related disorders and range from 12-step programs to psychopharmacology (Kingston & Firestone, 2008). Some treatment concepts work to rebuild the structure of self, attain control of affect dysregulation, and allow structural evolution of the affectional systems (Schwartz & Southern, 1999). Focusing on symptom change techniques in psychotherapy, such as relapse prevention, abstinence, arousal reconditioning, and social and empathy skills training, are necessary but rarely sufficient (Schwartz & Southern, 1999).

Others work to help clients master the experience of bonding and attaching in enduring and trusting intimate connections with others (Schwartz, 1996). However, their challenge is to find specific strategies to assist clients to reach the objectives (Adams & Robinson, 2001). It seems that the profession is struggling with having conceptual theories or specific interventions, but not an integrated strategy that embodies both. Therefore, a holistic theory laden with awareness driven interventions such as Gestalt therapy may be able to fill this void in clinical practice.

### **Gestalt Therapy**

In the 1940s Fritz and Laura Perls founded Gestalt therapy with a focus on the phenomenology of the client (Perls, 1969). Allowing clients to objectively critique their usual thinking patterns, phenomenology allows for discernment between actual perceptions and feelings and past residue (Idhe, 1977). It is an approach based on certain views about people's alienation from themselves and others and about what can help them become more aware, integrated, and contactful with themselves, with others, and with their environment (Becker, 1993; Perls, 1969; Sherrill, 1986). It teaches therapists and patients the phenomenological method of awareness, in which perceiving, feeling, and acting are distinguished from interpreting and reshuffling preexisting attitudes (Wulf, 1996).

Gestalt therapy views the body and its total processes as somehow anterior to and bigger than the mind (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). The mind blocks the total momentum of the organism in some way, it in fact works against the best interest of body/person (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). The mind is not the center of the body but rather the center of the dishonesty that the person has about themselves (Becker, 1993). Furthermore, Gestalt therapy believes that children distort their awareness of the world to become adults (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). They become dispossessed of their senses, fragmented within the self by the mechanisms of defense and cut off reality (Becker, 1993). This process begins in childhood where the child begins to exercise his or her own activities and becomes blocked by adults, or others in the environment whom stunt movement and the pursuit of satisfaction (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). These adults act out of their own anxieties and effectively stop the child's assimilation of experience (Becker, 1993).

Adults have incredible power over children. A child needs love and the feeling of importance which builds their self-esteem (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). To achieve the self-esteem the child must accept the adults' blocking of their action to receive acceptance or face the consequence of abandonment. This means

that the child develops a world perspective where he tries, by braking his own action and pleasure, to not displease them (Becker, 1993). Therefore, the understanding of “good” and “bad” within the self does not come from the child but rather the environment.

Since all children receive blocks from adults, Gestalt therapy believes that during human development no one is able to avoid neurosis (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). Every adult is off-centered because their own actions have been delegated to someone else in their environment (Becker, 1993). Because the power of providing self-esteem is out of the individual’s hands, they use neurosis to find self regulation. This is a dishonest style of “self” that is oblivious to the individual. Neuroses are an inefficient and often self-defeating self regulation (Becker, 1993). People give up awareness of self, world, authentic self-control, and self-governing to find self-esteem. There is an undercurrent to continue moving forward, even though the individual’s actions now reflect motives that are not their own, but of others (Becker, 1993). Ultimately people don’t know what they are doing because the roots are from before they can understand, childhood.

Therefore, the goal of Gestalt therapy is to develop people’s awareness about what is really happening to them, what they really want, what they are really striving for, where the organism is looking, and where their attention is drawn (Becker, 1993; Friedman, 1999; Idhe, 1977; Imes, Clance, Gailis, & Atkeson, 2002). A basic tenet of Gestalt therapy is that without awareness there can be no change (Perls, 1969). Therapy should help the person gain back protection and re-centering of power (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). Blocks are discovered and an understanding of why these blocks have not been examined before. To reach the Gestalt goals various techniques are employed that let people discover in practice their own activities in the world. Possessions of themselves, their motives, unconscious aspects of self, and what they are doing unbeknownst to them are sought after (Becker, 1993). Choicefulness is created in which the individual may decide to keep doing what they are doing or to try something different (Friedman, 1999).

To regain possessions a client needs to work on communication and interaction with the environment (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). Fritz Perls (1969) describes the environment as a field and the “self” cannot be understood in any other way than through that field. The here-and-now becomes the backbone of the therapeutic encounter as it is viewed as more reliable than any interpretation the clinician or client could offer (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). The observations during session assist the individual to consider themselves from the inside, the consciousness itself and its structure (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). The field becomes clear when experiences present themselves to the consciousness (Wulf, 1996).

An important point for awareness is the discovery of where the field and the organism meet (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). This contact boundary is not rigid but has a foreground and a background which is continually shifting (Perls, 1969). What emerges as the focal point in the field may be different at any given moment. Figures in the perceptive field emerge because of the objective properties of the person’s internal organization (Sherrill, 1986). The issue for individuals is when the focal point is met with inhibition due to blocks presented by adults in childhood, a personal conflict emerges (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). One part of the



self turns against another. These splits of the self are described in Gestalt therapy as polarities (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996).

Integration of polarities requires not only awareness but acceptance (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). The individual must become aware that two opposing poles exist within themselves and cause conflict (Becker, 1993; Perls, 1969; Sherrill, 1986; Wulf, 1996). Once they are identified, the individual is freed to work on accepting the two selves and negotiate how and when these separate parts will interact with the field (Becker, 1993; Perls, 1969; Sherrill, 1986).

Sexual problems in Gestalt therapy are conceptualized by valuing the role that “body” plays (Becker, 1993; Friedman, 1999; Perls, 1969; Sherrill, 1986). The organism does not use its body for evolution but against itself by the tyrannies of its own experience (Becker, 1993). The body becomes the focus for negotiating existential problems (Becker, 1993; Perls, 1969). Sexual rebellion is, in part, the individual’s attempt to use their bodies for themselves (Becker, 1993). This act is a method for regaining homeostasis, an internal attempt for balance, when there is unfinished business from childhood (Perls, 1969).

If the childhood situation is one in which they have been conditioned, they are not conditioned mentally but physically (Becker, 1993). The body and mind function as a totality, so mental unblocking must be accompanied with physical acting (Perls, 1969). Therefore, Gestalt therapy techniques incorporate a great deal of physical movement and experimentation (Becker, 1993; Friedman, 1999; Idhe, 1977).

### **Implications**

While Gestalt therapy does not address all the constructs a theory needs to comprehensively treat sexual compulsivity, it does hold necessary components to be included in a multi-modal model. Being that sexual compulsivity is hallmarked with dissociation, Gestalt therapy offers the reintegration. Compatible with the research defining sexual compulsivity, Gestalt therapy also offers a conceptualization of human nature and development in a congruent framework.

As evidenced in this article, there is an overwhelming need for unification of thought. Until the body of literature moves from fragmented contributions that wrestle with the complexity of behavior vs. addiction, compulsivity vs. impulsivity, theory vs. specific interventions, there can be no movement towards best practices. The parallel nature of Gestalt therapy constructs and empirically acknowledged elements of sexual compulsivity warrant further investigation. Specifically, research investigating Gestalt therapy techniques alone, as well as within a multi-modal plan, should be conducted. These studies should work to address the overall theoretical constructs of the theory but also the specific interventions. Hopefully, the outcome of such research will prove the efficacy of Gestalt therapy and lead to the formulation of a structured multi-modal treatment.

### **Conclusion**

In the case of Jane, her story is more than that of a self destructive sexuality. Inhibiting or even eliminating these problematic behaviors alone doesn’t “fix” the

problem. Effectively that was the result of her involvement with family services. She was forced to make specific lifestyle changes and she complied, but what quickly emerged was an intensity of emotion that she was unequipped to handle. As the previous sections have attempted to show, her sexual compulsivity was part of a much larger process that involved every aspect of her humanness. Neglect of any one aspect in the therapeutic process leaves open the potential for continued dysfunctions and neuroses.

Further exploration of Jane's story reveals that the absence of a consistent and responsive father combined with an inattentive mother left her with a skewed perception of herself and others, and their relationship to each other and to the environment. It is clear from her own well rehearsed words that she has no worth and others only want one thing, not her, only what she can do for them. This led seamlessly to a loss of self and the acceptance of others' wants and desires without defined boundaries that characterize healthy and fulfilling relationships. It was easier to relinquish herself than to come face to face with the painfully intense emotions of loneliness and abandonment that these encounters masked.

Regardless of the destructiveness of these behaviors as a whole, they worked, albeit temporarily, to constrict the emotions Jane had no other tools to deal with. As Adams' (2002) work previously demonstrated, these behaviors became habits that underscore and drive the sexual compulsivity. They are further perpetuated by the cycle of seeking intimacy through means that prevent any form of sustained intimacy, which only intensifies constricted affect and the need to continue the self destructive habits. This process is maintained by Jane's fragmentation of the self to disconnect her identity from her actions in order to block awareness of her internal realities. Choice is abandoned because her perceived self is too fragile to handle the blatant contradictions.

As the basic tenet of Gestalt therapy illustrates, change doesn't occur without awareness, and this is where Jane's change process began. During one session early in treatment, she was asked how many sexual partners she had had in the little more than a decade she was sexually active. Her flat and automatic answer was, "hundreds." Utilizing Gestalt's emphasis on the here-and-now, she was encouraged to repeat that statement to herself several more times. As she was forced to stare into the reality of that staggering number her entrenched façade was shattered by the tears falling from the terrified eyes of a little girl.

## **References**

- Adams, K. M. (1999). Sexual harassment as cycles of trauma reenactment and sexual compulsivity. *Sexual Addiction & Compulsivity*, 6, 177-193.
- Adams, K. M. (2002). Sexual harassment revisited: An opinion. *Sexual Addiction & Compulsivity*, 9, 87-88.
- Adams, K. M., & Robinson, W. R. (2001). Shame reduction, affect regulation, and sexual boundary development: Essential building blocks of sexual addiction treatment. *Sexual Addiction & Compulsivity*, 8, 23-44.
- Becker, E. (1993). Growing up rugged: Fritz Perls and Gestalt therapy. *The Gestalt Journal*, 16(2) 123-134.
- Bowlby, J. (1988). *A secure base*. New York, NY: Basic.

- Carnes, P. (1983). *Out of the shadows: Understanding sexual addiction*. Minneapolis, MN: CompCare.
- Creeden, K. (2004). The neurodevelopmental impact of early trauma and insecure attachment: Re-thinking our understanding and treatment of sexual behavior problems. *Sexual Addiction & Compulsivity*, 11, 223-347.
- Friedman, H. R. (1999). A gestalt approach to sexual compulsivity. *Sexual Addiction & Compulsivity*, 6, 63-75.
- Goodman, A. (1993). Diagnosis and treatment of sexual addiction. *Journal of Sex and Marital Therapy*, 19(3), 225-251.
- Griffin-Shelley, E., Benjamin, L., & Benjamin, R. (1995). Sex addiction and dissociation. *Sexual Addiction & Compulsivity*, 2, 295-306.
- Hagedorn, W. (2009). Sexual addiction counseling competencies: Empirically-based tools for preparing clinicians to recognize, assess, and treat sexual addiction. *Sexual Addiction & Compulsivity*, 16(3), 190-209.
- Herwig, U., Kaffenberger, T., Jäncke, L., & Brühl, A. B. (2010). Self-related awareness and emotion regulation. *NeuroImage*, 50(2), 734-741.
- Idhe, D. (1977). *Experimental phenomenology*. New York, NY: Putnam.
- Imes, S. A., Clance, P. R., Gailis, A. T., & Atkeson, E. (2002). Mind's response to the body's betrayal: Gestalt/existential therapy for clients with chronic or life-threatening illnesses. *JCLP/In Session: Psychotherapy in practice*, 58(11), 1351-1373.
- Kafka, M. P. (2007). Paraphilia-related disorders: The evaluation and treatment of nonparaphilic hypersexuality. In S. R. Leiblum (Ed.), *Principles and practices of sex therapy* (4th ed., pp. 442-476). New York, NY: The Guilford Press.
- Kingston, D. A., & Firestone, P. (2008). Problematic hypersexuality: A review of conceptualization and diagnosis. *Sexual Addiction & Compulsivity*, 15(4), 284-310.
- Leiblum, S. R., & Rosen, R. C. (1988). *Sexual desire disorders*. New York, NY: Guilford.
- Leiblum, S. R., & Rosen, R. C. (1989). *Principles and practice of sex therapy*. New York, NY: Guilford.
- Leedes, R. (2001). The three most important criteria in diagnosing sexual addictions: Obsession, obsession, and obsession. *Sexual Addiction & Compulsivity* 8, 215-226.
- Main, M., & Solomon, J. (1995). Discovery of an insecure, disorganized/disoriented attachment pattern: Procedures, finding, and implications for the classification of behavior. In M. Yogman & T. B. Brazelton (Eds.), *Affective development in infancy* (pp. 95-124). Norwood, NJ: Ablex.
- Perera, B., Reece, M., Monahan, P., Billingham, R., & Finn, P. (2009). Childhood characteristics and personal dispositions to sexually compulsive behavior among young adults. *Sexual Addiction & Compulsivity*, 16(2), 131-145.
- Perls, F. (1969). *Gestalt therapy verbatim*. Highland, NY: The Gestalt Journal Press.
- Raymond, N. C., Coleman, E., & Miner, M. H. (2003). Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behavior. *Comprehensive Psychiatry*, 44, 370-380.

- Reid, R. C., Carpenter, B. N., & Lloyd, T. Q. (2009). Assessing psychological symptom patterns of patients seeking help for hypersexual behavior. *Sexual & Relationship Therapy, 24*(1), 47-63.
- Rosen, R. C., & Leiblum, S. R. (1995). *Case studies in sex therapy*. New York, NY: Guilford.
- Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 7-66.
- Schneider, J. P. (2004). Sexual addiction & compulsivity: Twenty years of the field, ten years of the journal. *Sexual Addiction & Compulsivity, 11*, 3-5.
- Schwartz, M. F. (1996). Reenactments related to bonding and hypersexuality. *Sexual Addiction & Compulsivity, 3*, 195-306.
- Schwartz, M. F., & Southern, S. (1999). Manifestations of damaged development of the human affectional systems and developmentally based psychotherapies. *Sexual Addiction & Compulsivity, 6*, 163-175.
- Schwartz, S. A., & Abramowitz, J. S. (2003). Are nonparaphilic sexual addictions a variant of obsessive-compulsive disorder? A pilot study. *Cognitive and Behavioral Practice, 10*, 373-378.
- Sherrill, R. E. (1986). Gestalt therapy and gestalt psychology. *The Gestalt Journal*. Retrieved from <http://www.gestalt.org/sherrill.htm>
- Simons, J. S., & Carey, M. P. (2001). Prevalence of sexual dysfunctions: Results from a decade of research. *Archives of Sexual Behavior, 30*, 177-219.
- The Society of the Advancement of Sexual Health (n.d.). Retrieved from [http://www.ncsac.org/general/about\\_main.aspx](http://www.ncsac.org/general/about_main.aspx)
- Wulf, R. (1996). The historical roots of gestalt therapy theory. *Gestalt dialogue: Newsletter of the Integrative Gestalt Centre*. Retrieved from <http://www.gestalt.org/wulf.htm>
- Zapf, J. L., Greiner, J., & Carroll, J. (2008). Attachment styles and male sex addiction. *Sexual Addiction & Compulsivity, 15*(2), 158-175.

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