Substance abuse and dependence rarely occur in a vacuum. An internal Caron research study that analyzed 485 patient charts in its inpatient residential drug and alcohol treatment center found that 71.8% have a co-occurring psychiatric disorder, thus complicating the patient profile. This level of comorbidity is not unusual in the substance abuse population, but increasing recognition of the role that process addictions may play as a relapse factor has grown in popularity.

Coexisting addictions such as drugs and alcohol, disordered gambling, sex, food, work, Internet and gaming can become chronic and progressive if left unidentified and untreated. Most addicts today are faced with more than one addiction. Many of these addictions not only coexist but interact, reinforce and fuse to become part of a package—a process referred to as addiction interaction. These addictions are believed to operate in the same way as substances. They often work on the same neurotransmitters as alcohol and drugs. There has been a trend toward thinking about nondrug addictions as sharing the same neurobiological mechanisms with substance abuse and dependence (Deadwyler, 2010; Petry, 2006; Volkow & Wise, 2005).

These behavioral addictions often go unrecognized during substance abuse treatment yet play a vital role in an individual’s ability to remain sober. Frequently, these behavioral addictions come to the fore as “replacement” addictions and may be used to compensate for a substance. Untreated, process addictions can create as much havoc in a person’s life as any substance. They often have the associated withdrawal and tolerance symptoms seen in addiction along with the unmanageability leading to social, occupational and relational problems.

Comorbidity of sexual addiction with substance abuse has ranged from 64% (Black, Kehrberg, Flumerfelt, & Schlosser, 1997) to 71% (Raymond, Coleman, & Miner, 2003) in studies surveying individuals with sexual addiction. The Caron research study was conducted among the adult drug and alcohol patient population within several programs to determine what percentage may be at risk for sex and love addiction. The Caron study was conducted among the adult drug and alcohol patient population within several programs to determine what percentage may be at risk for sex and love addiction. The 485 participants were given the Sexual Addiction Screening Tool-Revised (SAST-R; Carnes, Green, & Carnes, 2010). In that study, 21% of individuals being treated for substance dependence scored as at risk using the SAST-R. This research also showed significant differences between men and women in regard to sexually addictive behavior. Men are significantly more likely to have a preoccupation with sexual matters and engage in the use of the Internet more for sexual purposes.

Caron’s research showed a higher percentage of cannabis, cocaine and amphetamine abuse or dependence diagnoses in individuals at risk for sexual addiction as compared to those not at risk. In addition, at-risk individuals had higher percentages of mood disorder, PTSD and eating disorder diagnoses (see Tables 1 and 2 on p.36).

Risk Factors

In examining the rates of childhood sexual abuse from the Caron study, 46.7% of women who scored as at risk on the SAST-R reported a history of childhood sexual abuse as compared to the group not at risk (26.0%). Sex addicts typically struggle with underlying psychological or emotional issues stemming from early life abuse such as emotional neglect, sexual abuse and physical abuse. Risk factors include:

- Family history—genetic predisposition to addiction of alcohol and drugs;
• Psychiatric disorders such as depression, anxiety or mood disorders;
• Higher rates of behavioral addictions in the family throughout generations such as gambling, sex, food, work, Internet, gaming;
• Childhood trauma (sexual, psychological and/or physical);
• Post-traumatic stress disorder (PTSD);
• Dysfunctional family dynamics, which may include the normalization of sexualized behaviors or talk in front of children.

Case Study and Treatment: Caroline, Age 40

History of Problem
Caroline is a Caucasian female married with two daughters, ages 12 and 9. She was admitted for polysubstance dependence and also carried a diagnosis of PTSD by history. This was her fourth inpatient residential treatment for substances, and she had three previous outpatient attempts. She is a stay-at-home mother who finished high school and attended 2 years of college. She married her husband when she was 27. She describes the relationship as more friends than lovers. She reports significant sexual difficulties within the relationship, and she has been involved in numerous Internet affairs. Her husband is aware of a current affair.

Caroline’s parents divorced when she was 8. Her father was an alcoholic and introduced her to alcohol and marijuana. Her mother remarried when Caroline was in fifth grade, again to an alcoholic.

Caroline reported a long history of sexual abuse by her paternal grandfather from ages 5 to 16 causing night terrors as a child. Caroline stated that the sexual abuse occurred when substances were involved—alcohol, marijuana and cocaine. She reported exposure to pornographic material by family members and open discussion about sex. This became the family norm. Caroline reported recurring flashbacks and dissociative episodes when the feelings surrounding the trauma were overwhelming. She reported a history of using substances to “numb the flood of feelings.”

Caroline began using alcohol and marijuana at the age of 14 on a chronic basis. She reported drinking 1/5 liter of vodka daily and at times Klonopin used nasally, marijuana and cocaine. A month prior to treatment she reported suicidal ideation with a plan; however, she did not make an attempt and instead sought treatment.

Caroline was admitted to Caron’s Women’s Program for gender separate treatment and after her 30-day stay moved to the Women’s Extended Care Program for another 90 days. She completed a total of 126 days of treatment.

Treatment Highlights
During her treatment stay, Caroline actively participated in a variety of specialty groups designed to assist her with greater self-awareness, emotional regulation, relapse prevention and increased coping strategies.

Throughout the course of treatment, Caroline struggled with separating herself from her disease of addiction to substances and sex. There was significant shame, distorted beliefs and intrusive thoughts. She often operated from the belief that this was the way she was born and that there was nothing she could do to make changes for herself.

She wanted to achieve a life of recovery,
SUBSTANCE ABUSE & SEX ADDICTION

Table 1

<table>
<thead>
<tr>
<th>Substance Use Diagnoses</th>
<th>No Risk</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>17.0%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>17.0%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>8.9%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

Table 2

PERCENT OF INDIVIDUALS AT RISK AND NOT AT RISK FOR SEXUAL ADDICTION DIAGNOSED WITH MOOD DISORDER, PTSD OR EATING DISORDER

<table>
<thead>
<tr>
<th>Psychiatric Diagnosis</th>
<th>At Risk</th>
<th>No Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>25.4%</td>
<td>20.4%</td>
</tr>
<tr>
<td>PTSD</td>
<td>31.7%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>0.5%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

serenity, and find peace of mind and confidence in her decision making. The Caron Treatment Model Approach was an integrated multidisciplinary 12-Step treatment process that addressed both addictions as a parallel process.

Assessments

Caroline was administered several psychological assessments to assist in clarification of diagnosis and character structure. These assessments included the Minnesota Multiphasic Personality Inventory-Revised Format (MMPI-RF; Ben-Porath & Tellegen, 2008) and Sexual Dependency Inventory-Revised 3.0 (SDI-R 3.0; Carnes, 2008).

The MMPI-RF indicated that she had a tendency toward self-disparagement and felt the need to punish herself for her “unacceptable behaviors.” Results also indicated problems with externalizing behaviors most likely linked to a history of sexual acting out and substance abuse. Results also indicated a difficulty with impulse control and tendency toward sensation-seeking. There was some evidence that she felt persecuted by others and she experienced self-doubt, insecurity and inferiority.

Caroline was administered the SDI-R 3.0 (Carnes, 2008) approximately 2 1/2 months into extended care treatment after she scored an 8 on the SAST-R, indicating risk for sexual dependency. Caroline’s scores exceeded the clinical threshold for sexual dependency, elevations on emotional distress, demoralization, ideas of persecution, substance abuse and interpersonal passivity.

Caroline also showed SDI-R Behavioral Scale elevations on Seductive Role (SR) and Drug Interaction. These elevations are directly related to the fusion of her childhood sexual abuse and use of substances. The association between sexual behavior and substances also reinforced the notion that sex provided her with value and power in that sexual contact garnered affection, albeit short-lived, and drugs/alcohol. This association was reinforced by her abuser as well as subsequent sexual partners.

Caroline scores on the Fantasy (F) and Masturbation (M) scales were also elevated indicating a “tolerance” where “normal” sexual experience was no longer sexually arousing. Sexual arousal required taboo fantasy (multiple partners, infidelity, rape fantasy). Caroline sought sex outside her committed relationship, which included the taboo fantasy material. In addition, Caroline had fantasies around multiple sexual partners and a perceived link between sex and love as demonstrated in her extramarital affairs.
Twelve-Step Philosophy
Throughout her treatment, there was 12-Step integration, including readings/discussion from the Big Book of Alcoholics Anonymous (Alcoholics Anonymous, 4th ed., 2001) and the Twelve and Twelve (Alcoholics Anonymous, 1981). Caroline completed a co-addiction First Step around her chemical dependency. By doing so she was able to recognize the powerlessness and unmanageability in her life that related to her sex addiction.

Considerable focus was given to Steps One through Five of Alcoholics Anonymous. On a daily basis, Caroline completed a daily Tenth Step Inventory. Working the 12 Steps of AA helped her to increase her self-awareness and accountability for her own recovery. She actively utilized her AA sponsor for support and direction. She became part of a sober support system with other recovering women. She also began to engage in Sex and Love Addicts Anonymous (SLAA) fellowship before she was discharged.

Trauma Safety Group
Caroline was able to gain insight into the impact that her trauma and unresolved family-of-origin issues have had on her belief system. Caroline would ruminate on thoughts such as “people don’t like me,” “sex is my only value,” “this is what I deserve” and “this is who I am.” Caroline became aware of the connection between abandonment, rejection and substance/sex addiction. She recognized the repetitive behavioral patterns of how this played out in her relationships.

Art Therapy
Caroline used art therapy as a means to communicate difficult feelings and record her history. She completed several pieces of artwork that expressed generational addiction, internalized shame and rage, as well as hope for her and her family’s recovery.

Family Work
Regular family sessions were held with Caroline and her husband. The goal was to explore honesty and develop open communication. Her husband received education regarding addiction interaction. Part of Caroline’s homework during the marital sessions was to educate her husband on her newfound insight regarding how she manifested maladaptive behaviors to get her emotional needs met. She took risks to share about her compulsions, addictive thinking and fears. She set some boundaries that were approached in terms of relapse triggers. The boundaries included no discussion of the sexual addiction outside of a therapeutic setting, sexual abstinence during treatment and on therapeutic passes. She requested that her husband not engage in any verbal fantasies, which had acted as a relapse trigger for Caroline in the past.

Caroline addressed the impact her addiction had on her relationships with her children. She also had to examine the devastating effects of her addiction on her ability to parent. She addressed specific irresponsible parenting behaviors, ways she could better communicate with her children and how she could begin to make amends and regain their trust. Caroline completed a collage that contrasted her role as a mother in active addiction with what she hopes to achieve as a mother in recovery.

Completion of Treatment
Caroline, at the end of her treatment, seemed to be internalizing her powerlessness over substances and sex. Psycho-education helped to normalize some of her sexual behaviors as a result of childhood sexual trauma. The spiritual awakening and growth that occurred over the course of treatment allowed her peace of mind and insight into her worthiness.

At the end of treatment, Caroline left with a referral to a certified drug and alcohol counselor who was also a certified sexual addiction counselor. Her husband was given a referral to a therapist for ongoing relationship work. It was also recommended that he attend 12-Step meetings for spouses. In addition, suggestions were made that her children receive ongoing counseling and attend Ala-Teen. She left with an individualized continuing care plan and a commitment to participate in Recovery Care Support Services for one year through Caron. Her husband also made this commitment.

Conclusion
This case presented a complicated picture of the interwoven nature of substance dependence and sexual addiction.
Patients like Caroline oftentimes have severe underlying problems that are deeply ingrained into their sense of who they are and the behaviors that they exhibit. Unfortunately, often these problems do not come to light during the course of substance abuse treatment and the behavioral addictions go unidentified.

First and foremost, the need for a complete evaluation of the individual presenting for treatment cannot be emphasized enough. It is important to not only gather a detailed substance abuse and mental health history but also a complete view of the whole patient, which means exploring potential behavioral addictions and past trauma in detail. It is also helpful to have a good understanding of the individual’s generational history (relative’s substance use, mental health, trauma and process addictions). The evaluation should be ongoing throughout treatment as often behavioral addictions may not come to the fore until later in an individual’s stay. If an individual is identified as having a sexual addiction it is imperative to bring into awareness not only the problem (there may be more denial to work around than with substance abuse because of the shame) but of how it interacts with the use of substances. It is also important to help the individual to understand the higher risk for relapse and signs of relapse for both the substance as well as the behavioral addiction. Work around the sexual addiction needs to include helping to resolve shame, guilt and anger as well as allowing the patient to grieve the loss of the behavior as much as they might grieve the loss of the substance. Fostering an in-depth, integrated knowledge of the 12 Steps, both for substance abuse and sexual addiction, is very important. Extended treatment should also be a consideration. For a patient moving from inpatient to outpatient treatment it is important to ensure that a referral is made to a clinician with knowledge and experience of chemical dependency treatment and sexual addiction.

With the emerging recognition of behavioral addictions, it is important to educate chemical dependency counselors on addiction interaction disorders in order to help recognize these issues in their patients. It is important for the clinician to understand the concept of chemical dependency fusion (needing a substance to engage in a behavior) and replacement (using the behavior as a replacement for the substance). Supervision is important to help a clinician deal with issues of transference and countertransference with these patients. This is important to help the addictions counselor increase his or her comfort level on a topic that often is uncomfortable to discuss.

Increasingly, clinical competence is necessary when looking at addiction as a family disease. Children and spouses from these families need individual therapy due to the sensitive nature of the behavioral acting out. For individuals with children it is imperative that they improve parenting skills and learn to set appropriate boundaries.

In conclusion, sexual addiction is not uncommon in the substance abuse population with approximately 20% of substance abusers also having process addictions (as shown in the Caron study). Many addicts today struggle with more than one coexisting addiction. An integrated multidisciplinary 12-Step treatment approach, as utilized in this case, has proven an effective model of intervention. Recognition and treatment of the co-existing addictions can immensely help in the abstinence process and increase awareness of behavioral addiction triggers that can interfere with a patient’s recovery and lead to relapse.
Erin Deneke, PhD, LPC, is the director of research at Caron Treatment Centers. Dr. Deneke’s research focuses on chemical dependency, behavioral addictions and recovery. In addition, she specializes in the treatment of trauma, substance dependency and LGBT issues. She has presented at a local, state and national level.

Michele Pole, PhD, CSAT, is a licensed psychologist working at the Women’s Extended Care Program at Caron Treatment Centers. Dr. Pole specializes in the treatment of sexual trauma, PTSD and eating disorders. Her theoretical orientation is primarily, but not exclusively, the third-wave of CBT including mindfulness-based approaches and dialectical behavior therapy.

Jillayne Rech, MHS, MBA, CAC, ICADC, CSAT, is the lead addictions counselor at the Women’s Extended Care Program at Caron Treatment Centers. She is a certified addictions counselor and certified sex addiction therapist who has worked for over 15 years in the field of addictions. She specializes in the treatment of chemical dependency in women with co-occurring issues such as sex addiction, trauma, family of origin, relationship issues, eating disorders, and grief and loss.

References:

Caron Integrated Treatment Model

**Inpatient 30-day**
- Comprehensive biopsychosocial evaluation
- Medically supervised detoxification and treatment
- Psychological/psychiatric evaluation
- Psychological Testing:
  - MMPI-2-RF
  - SAST-R
- Sexual Dependence Inventory (SDI) if needed
- 12-Step Integrated Treatment and Meetings
- Individual sessions with certified addictions counselor
- Individual session with Certified Sex Addiction Counselor (CSAT)
- Group therapy
- Individual family sessions/5-day Family Education Program/Child and Teen Program
- Individual spiritual counseling
- Psycho-educational groups (disease of addiction, addiction interaction, coping skills)
- Recovery for life skills
- Relapse process and warning signs group
- Art and music therapy

**Patients in Extended Care receive in addition to the above:**
- 90-days of treatment
- Specialized trauma group for women/men
- Family of Origin group work
- Parenting group
- Body Image group
- Addiction Interaction group
- Emotional Regulation group
- Grief and Loss group
- Ongoing family sessions and 4-day Family Education Program
- Sex-Methamphetamine, Alcohol, Cocaine, Ketamine, Ecstasy and DMX (SMACKED) group
- Addiction Interaction work using Carnes Task Model (Facing Addiction [2011], Facing the Shadow [2010], and Recovery Zone [2009])

**Continuing Care**
- Individualized Continuing Care plan with Recovery for Life Commitment
- Recovery Care Services for patient and family
- Referral to CSAT outpatient provider
- 12-Step meetings (AA, NA, SLAA, SA)