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# SEXUAL ADDICTION & COMPULSIVITY

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# ASSESSING SEXUAL COMPULSIVITY/ ADDICTION IN CHEMICALLY DEPENDENT GAY MEN

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*Gays experience something like a second adolescence as part of the coming out process. During that time, behavior could be confused with sexually compulsive behavior. Gays also experience shame due to heterosexism. Coping mechanisms for shame can include the use of mood altering substances as well as compulsive sexual behavior. The Sexual Behavior Assessment Tool (SBAT) is a way to assess the sexual behavior and delineate sexual compulsivity from coming out behavior. Case examples are given in this article to demonstrate the difference between coming out issues and sexually compulsive behavior in gay men.*

## INTRODUCTION

The key factor in assessing the gay, lesbian, or bisexual client for sexual compulsivity is understanding the stages of the coming out process. Behavior, commonly understood as sexual compulsivity, may actually be a phase in the client's process of coming out to him or herself. Before concluding that a gay, lesbian or bisexual client is sexually compulsive, determine the client's developmental stage of coming out. The "coming out process" could be compared to a second adolescence. It is a developmental stage but can happen during any age of the chronological process. Two such theoretical models were developed by Cass (1979) and Coleman (1981/1982).

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Vivienne Cass (1979) identified six stages of the coming out process in a theoretical model. This model was used at Pride Institute, a treatment center exclusively for chemically dependent gay/lesbian/bisexual/transgender clients, in assigning coming out levels to each client for the purpose of developing a sexual behavior instrument. The six stages are Identity Confusion, Identity Comparison, Identity Tolerance, Identity Acceptance, Identity Pride, and Identity Synthesis.

Eli Coleman (1981/1982) developed a similar developmental model using five stages. The five stages are pre-coming out, coming out, exploration, first relationships, and identity integration.

There are two purposes in writing this article. The first is to assist the clinician in differentiating between sexual compulsive behavior in gay males and behavior common to coming out issues. The second purpose is to assist the clinician in understanding the role sex addiction plays in some chemically dependent gay men.

### *Methods*

Through comprehensive assessment tools conducted on intake we discovered that forty percent of our clients reported some type of compulsive sexual behavior. Originally, we used an instrument known as the Gay Sexual Addiction Screening Test (SAST). We quickly determined that this instrument was geared more to gay male behavior and not sensitive to the issues surrounding lesbians and bisexuals. A task force was developed to create a new comprehensive instrument.

During the process, primary counselors assigned a coming out level to each client as they conducted interviews for our comprehensive psychosocial. During the interview, clients gave a full sexual history and answered the following questions regarding their sexual orientation:

1. Who in your family, friends and workplace knows of your sexual orientation?
2. What is the level of acceptance by family of your sexual orientation?
3. If you could change your sexual orientation, would you? 4. How do you feel about your sexual orientation?

Based upon the answers of these questions, counselors then assigned a level for that person's stage of coming out.

Counselors were provided a sheet with a synopsis of Cass's (1979) six stages of homosexual identity formation. One hundred thirty-seven clients were surveyed using this process. Over two thirds of our clients were assessed

as being in the first three stages of identity formation (Identity Confusion, Identity Comparison, and Identity Tolerance).

In order to do a more adequate assessment, we have asked the following questions as part of conducting a sexual history:

1. How old were you when you had your first sexual experience? How old was the other person?
2. Describe your first sexual experience with an adult.

It is not uncommon to hear a response like age 16 with another 16- or 17-year-old in answer to the first question followed by a story where the client was much younger in the answer to Question 2. Question 2 often involves stories with family members, teachers, clergy, counselors, Boy Scout leaders, neighbors, babysitters or other adults in “nurturing” positions.

The correlation of chemical use and these sexual histories is also important for the assessment. All of our clients complete a Chemical Use History in three stages. It is not unusual to see marked increase in chemical abuse at the onset of coming out issues and abuse issues described above. For the person exhibiting compulsive sexual behavior we have developed the following tools:

1. The primary counselor completes the psychosocial including the sexual history and sexual orientation issues.
2. All clients attend instructional workshops on “What Is Abuse” and on “Sexual Compulsivity and Addiction.”
3. A support group for those who identify sexual compulsivity is offered to discuss such issues in confidence with peers and a trained facilitator.

If a client or the primary counselor questions sexual compulsive behavior, the SBAT (Sexual Behavior Assessment Tool) is administered. The SBAT is the instrument we developed after our clinical study using the Cass model and looking at the behavior of our trial population. Once the client completes the SBAT, the primary counselor or facilitator of the Sexual Compulsivity Support Group consults with the client regarding his/her answers. If sexual compulsivity is deemed an issue, the client completes a Sex and Love History, which is presented in the Sexual Compulsivity Support Group. If this issue continues to be assessed as a barrier to recovery, the client completes a First Step for sexual compulsivity followed by relapse assignments on dual addictions. Prior to discharge, a client is expected to develop a definition of abstinence and boundaries for sexual behavior.

### *Results and Discussion*

It is striking that many therapists have assumed that a client who would self-identify enough to enroll in a gay identified treatment center would be in the later stages of identity formation. Not true. Many of our clients were struggling with their identity, which contributed to relapse issues with chemicals as well as with unwelcome sexual acting out practices. The discerning clinician needs to delineate the difference between outward labeling of sexual orientation and inner integration of what it means to accept one's sexual orientation.

A surprising number of clients continue to state that they would change their sexual orientation if that were possible, although they recognize that it is not possible. These are often individuals who are fully out to family and friends. Without such examination, these individuals were traditionally seen as accepting of their sexual orientation because they were "out" to others; when in fact, they only qualify for Stage Two of the process: somewhere between accepting their behavior as homosexual but devaluing what it means to be homosexual.

Consider "Bill." Bill was in his mid twenties and came to treatment with a dual diagnosis of Chemical Dependency and Sexual Addiction. Bill had grown up in a conservative Southern Baptist preacher's home. At an early age, Bill determined that he was gay. His father preached that gays were an abomination and going to hell. Out of desperation to find a "positive" identification for being gay, Bill moved to New York City when he turned 18. Bill found other men "like him" in subway bathrooms, gay bars and sex clubs. He became immersed in compulsive sexual activity with much guilt but telling himself that this is what it means to be gay. As his guilt and shame about his behavior deepened, so did his use of alcohol and drugs until inpatient treatment was required. Once Bill was in an all gay environment where he learned of diverse homosexual behavior, he learned that the sexual practices that he defined as gay were not necessary as part of the acceptance of being gay. Bill was not sexually compulsive after all: he had been practicing multiple anonymous sex because that was the only gay life that had been introduced to him. He so desperately needed to identify with others who were gay that he was willing to compromise his sexual values in order to "be gay." What a relief he felt when he realized that he now had options regarding his sexual behavior and still be identified as gay.

Another key factor in assessing gay and bisexual men is the issue of sexual abuse. Many gay and bisexual men do not identify adolescent experiences with older men as abuse even though the experiences meet clinical definitions of abuse. We found a significant number of clients answering "No" to the question of "Have you ever been sexually abused?" in our

initial assessments. During our thorough sexual histories we discovered that a number of these same clients reported having sex with older men in their adolescence. When questioned, these clients would report such comments as “It wasn’t abuse. I went looking for it. I enjoyed it. I wanted it. I returned for more.” Take the case of Jed.

Jed reported a lonely childhood. He knew that he was different from other boys. Other children had made fun of his effeminate behavior. Several of the boys in Jed’s neighborhood warned him to stay away from the “weird” guy down the street. Jed suspected that the “weird” guy may be weird in the same way that he was. Jed went to the “weird” guy’s home to discover that this man understood Jed’s “problems,” comforted him, and made him “feel good” by having sex with him. For the first time in Jed’s adolescence, he felt affirmed and accepted. He continued to return to the home to participate in this “acceptance.”

During the process of sharing Sex Histories in the peer group, the ability to assess the compulsive behavior as part of the coming out process rather than needing treatment for addiction becomes clearer. Let’s look at a couple of case studies for examples.

“Lester” was a middle-aged lawyer with multiple chemical dependency treatments. After a family intervention with support from his employer, Lester entered our facility for extended care. His counselor picked up on sexually compulsive behavior during the biopsychosocial interview. He was given a SBAT and referred to the Sexual Compulsivity Support Group. When Lester presented his Sex History in the group, it became evident that his behavior was focused around his shame about being gay. Lester used chemicals to get the courage to act out with men, while in his heterosexual marriage and since his divorce. He did not act out sexually when sober but had great fears regarding his performance with men. He was referred to a local support group for men who have sex with men. He continued in the Sexual Compulsivity Support Group by his own choosing but did not identify any further compulsive behaviors or preoccupation throughout his treatment.

“Doug,” in his late 20’s, came to the “optional” Sexual Compulsivity Support Group his first day in Chemical Dependency treatment. In the next group session, he presented his Sex History, which demonstrated progressive compulsive sexual behavior. Doug’s history began at age 6-10 by playing doctor with peers. From age 11-15 he was “picking up older men.” By age 16-20, his interest turned to Sado Masochistic behavior. In the 2 years prior to treatment Doug was using hustlers one to two times a week and is “addicted to violent hard core sex” (Doug’s words) with one person for 4-hour sessions. He expressed shame over revealing secrets he had never shared before. In his first step, Doug was clear about preoccupation and failed

attempts at being able to control his behavior. Consequences included dropping classes in school because he was having sex in the bathrooms, contracting herpes and anal warts by age 15, bruises from the S & M activities, lack of sleep due to cruising for hours, two suicide attempts, and an HIV diagnosis 2 weeks prior to entering treatment.

Lester clearly acted out sexually after using chemicals and used the chemicals to reduce the shame due to heterosexism. During treatment, Lester “came out” to his adult sons and involved them in the family program. The combination of working a program of sobriety for chemicals and becoming comfortable with his sexuality may reduce ongoing sexual compulsive behavior. Doug had been acting on his sexual addiction long before chemicals were a problem in his life. Although he is now chemically dependent, he will also need to work a program for his sexually compulsive behavior in order to reduce the pain of his shame and guilt to stay sober.

Doug also has a great deal of shame about being gay and will need to work on that issue as part of his continuing care plan; however, both the drug and sex addictions will need to be addressed in order to do this emotional work. Following the presentation of his Chemical Use History in the group, Doug expressed a strong desire to get drunk. Following his First Step for Sexual Addiction in the group, Doug could not initially identify any feelings but expressed the urge to leave treatment. The “flight or fight” syndrome of addiction was at work. After feedback from the group, Doug was able to express the pain, shame, and guilt of his behavior as well as the uncomfortableness with his sexual orientation. He demonstrated there in the group how he had used chemicals and sex to dissociate from his feelings. With the group’s help he was able to express the feelings. It is this practice in 12 Step groups for both addictions that will make therapy as well as recovery a workable tool for Doug. Because shame is a driving force for addiction, and shame due to heterosexism is such a force in a gay man’s life, addiction is a “natural” to deal with feelings. The power of the dual addictions works in the following way: a gay man attempts to stay sober from alcohol and drugs, he acts out sexually, which produces shame (due to heterosexism). The shame pushes the urge to use and he relapses.

### Conclusions

There are several factors to weigh in assessing sexual compulsivity/addiction in gay men, lesbians, and bisexuals. Clinicians need to obtain thorough sex histories as well as determine where the client lies in the process of coming out. Assessment tools then need to be used or developed regarding the actual sexual behavior in relationship to coming out behavior. Gay men, lesbians, and bisexuals undergo a second adolescence in the process of coming out.

During that process, which can be quite prolonged, especially if alcohol and drugs are involved, a client may be exhibiting behavior that commonly is diagnosed as sexual addiction. For some, finding ways to cope with the shame of being gay will reduce the sexually compulsive behavior. For others, the behavior has been a longer standing way of coping with shame and other feelings that have turned into a true addiction, often a dual addiction with chemicals, spending (especially shopping for gay men), eating disorders, gambling, and any other compulsive behavior. Because gays learn early in life how to hide their true identity in order to be accepted, the secret life of sexual addiction is a natural. It was often begun long before they used chemicals or other compulsive behaviors and is so much a part of who they are they define their behavior as what it means to be gay. The skillful clinician will ferret out the coming out issues apart from sexual compulsivity and addiction.

#### REFERENCES

- Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*, 219-235.
- Coleman, E. (1981/1982). Developmental stages of the coming out process. *Journal of Homosexuality, 7*, 31-43.
- Neisen, J. (1994). Counseling lesbian, gay and bisexual persons with alcohol and drug abuse problems. Arlington, VA: NAADAC Products.
- Neisen, J. (1993). Healing from cultural victimization: Recovery from shame due to heterosexism. *Journal of Gay and Lesbian Psychotherapy, 2*, 49-63.