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On: 14 August 2007
Access Details: [subscription number 781182499]
Publisher: Taylor & Francis
Informa Ltd Registered in England and Wales Registered Number: 1072954
Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Sexual Addiction & Compulsivity The Journal of Treatment & Prevention

Publication details, including instructions for authors and subscription information:
<http://www.informaworld.com/smpp/title~content=t713658059>

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Online Publication Date: 01 July 2007

To cite this Article: Kwee, Alex W. (2007) 'Constructing Addiction from Experience and Context: Peele and Brodsky's **Love and Addiction** Revisited', *Sexual Addiction & Compulsivity*, 14:3, 221 - 237

To link to this article: DOI: 10.1080/10720160701480535

URL: <http://dx.doi.org/10.1080/10720160701480535>

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Constructing Addiction from Experience and Context: Peele and Brodsky's *Love and Addiction* Revisited

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Peele and Brodsky (1975) first proposed the experiential-constructivist model of addiction utilizing the construct of compulsive interpersonal attachment (then not viewed as an addiction) as a vehicle to argue that substance addiction is rooted in experiential and contextual forces. One of these contextual forces is the prevalence of the disease mindset itself. With increasing legitimacy accorded to disordered love attachments as addiction "diseases," we can now explore this hypothesis in relation to sexual addiction using as illustration religious "chaste sex addicts" and Homosexuals Anonymous. Treatment recommendations are then considered in the light of effective interventions outside of the disease model.

LOVE AND ADDICTION

Stanton Peele is one of the most polarizing figures in the field of addiction treatment and research today. As a social psychologist who has spent much of his career resisting the notion that addiction is a disease, he has a well-earned reputation as a gadfly among the considerable number of medical and mental health professionals (such as those comprising the readership of this very journal) who hold the opposing view and work within the medical model of addiction treatment. As a therapist who believes in that model's clinical utility, I am nevertheless an interested observer of the debate that Peele has helped to perpetuate through his books and scholarly articles. I believe that the debate, i.e., addiction as a medical illness versus an experientially and socially constructed disorder, is a worthy one that we need to engage

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in for the sake of epistemological inquiry, self-examination, and improving our theories. It is in this spirit that I have undertaken writing this article to examine the contributions and controversies of the views of a major dissenter against the medical model of addiction.

Peele is by no means the sole critic of the disease model of addiction and the dominance of 12-step treatment programs, which he believes are largely ineffective and even counterproductive to the addict's ability to recover. However, I have chosen to use his ideas as a vehicle of discussion because I believe that Peele is the best representative of the anti-disease model camp given that he presents his arguments with a sophisticated level of empirical support and analysis, and, as a social psychologist and an attorney, he demonstrates an especially keen ability to think about addiction culturally, systemically, and legally.

Yet, why do I think this debate merits a place in *this* particular journal? It is because Peele's body of work on this subject began with the book *Love and Addiction* (1975), which he coauthored with Archie Brodsky. Even though *Love and Addiction* is now out of print, I consider it a foundational achievement in its piercing inquiry into the nature of addiction. This inquiry employed the construct of interpersonal addiction to examine what the authors believed to be addiction at its core—a spiritual and emotional impoverishment that causes the self to invest in some thing or person to obtain a sense of worth and security. Peele and Brodsky (1975) argued that the involvement in the thing or person yields temporary relief from emptiness, but because its continuance precludes growth and long-lasting fulfillment, it perpetuates a cycle of dependency by which the self atrophies and the addiction gradually becomes the sole condition of existence. Interpersonal addiction (or codependency, as it is more commonly known today) is the starkest expression of addiction because the addicted “group”—which like any other maintains dependency through its code of shared beliefs and conduct—is the smallest of all. Instead of a relationship to some drug, it is the very relationship between its two members that is the sole value, theme, and condition of their existence, to the exclusion of the growth and enhancement of each (Peele & Brodsky, 1975, pp. 68–70). The notion of selfish exploitation masquerading as selfless love has been explored with theological brilliance elsewhere, such as C.S. Lewis' (1946) *The Great Divorce*. For Peele, such disordered, mutually limiting attachment is addiction, the antithesis of love.

I believe that *Love and Addiction* was ahead of the times. When it was published in 1975, it pre-dated by almost a decade what came to be considered groundbreaking works on sex addiction by Patrick Carnes (1983), and on codependency by Melodie Beatty (1986). Indeed, it pre-dated the popular use of the terms “sex addiction” and “codependency” to describe legitimate disorders of love attachment since these terms were not part of Peele and Brodsky's nomenclature. Nevertheless, because *Love and Addiction* was concerned with observing the same condition of addictive human attachments,

it lays claim to being the first book written on the subject of codependency. This is why I believe this book is significant and merits a close second look against the backdrop of developments in the 32 years since its publication, during which sex/love addiction and codependency have become recognized in our society as real problems that warrant intervention.

PEELE'S POSITION ON ADDICTION

Peele admittedly holds the minority position—though it is a sizable, intelligent, and respected minority—that addiction must be understood as something else apart from a disease. Peele and Brodsky (1975) argued that addiction may only be understood in experiential terms. The experience is defined by the direct effects of a substance or behavior—the authors do not dispute that drugs have real effects and these effects differ from one drug to another—as well as a state of being unconnected to the direct effect of the drug. The authors noted, “In this state of being, whatever it is, lies the key to understanding addiction” (Peele & Brodsky, 1975, pp. 50). Some people get addicted to drugs, others do not in spite of regular use, and yet others mature out of their drug use or excessive behavior without treatment. What sets the addict apart, Peele argues from a plethora of research, is that individual characteristics like attachment insecurity and hopelessness converge with contextual factors—both immediate environmental demands and the social milieu—to create a compelling experience with the drug or behavior (Peele, 1985; Peele, 1998; Peele & Brodsky, 1975). This experience is one of imagined wellbeing and power that causes the addict to return to the drug or behavior until addiction develops. Addiction, then, is not a biologically based disease but a state of being characterized by repeated attempts of increasing futility to replicate a false experience of escapism, power, and security which the addict finds so compelling because of his existential insecurity. In this state of being, the organized predictability of the addiction becomes the only tolerable condition of life (Peele & Brodsky, 1975, pp. 60–70).

Love addiction speaks to the emptiness and alienation of the human condition in a technological world that turns the capacity for genuine love into self-seeking, disordered attachment. Peele and Brodsky (1975) used it as an example to argue that human experiences can be addictive, and it is not the inherent property of a drug alone that causes it to be addictive, but people's perceptions and experiences of the drug borne of their existential emptiness. That experiences can be addictive was a prescient notion in 1975 as psychology now embraces the concept of the process (or behavioral) addictions such as pathological gambling, compulsive eating, and sex addiction. But it must surely be to Peele's dismay that instead of rethinking substance addiction as a medical illness, psychology has gone and classified the behaviors as addictions in the same medical sense and yielded the solution into the hands of

the 12-steps. One does not have to be in complete agreement with Peele to appreciate that this mindset has been carried to a rather ridiculous extreme in our society today, as evidenced by the proliferation of 12-step groups to deal with an ever-expanding list of modern “addictions”—overspending, workaholism, “toxic” emotions, kleptomania, and lip balm addiction to give just a few examples.

“ADDICTION IDEOLOGY” AND THE 12-STEPS

In his relentless criticism of what he considers to be the dominant ideology of drug and alcohol addiction, i.e., these are diseases and must be treated as such, Peele summarily rejects the 12-step treatment approach because it is so woven in with this purported ideology (interested readers are referred to Peele, Bufe, & Brodsky (2000) for an epistemological critique of the 12-steps). However, I believe that embracing the clinical utility of the 12-steps does not necessarily mean subscribing to the disease view of addiction, and I wish to elaborate on this position—an unabashedly religious one—a little further. My point is not to argue for one religious viewpoint (in this case Christianity) against another but to show that the 12-steps, having religious roots and being inherently value-laden from its very conception, cannot help but be understood (and embraced or rejected) through the filter of one’s value and epistemological framework—and this, I believe, has little to do with the more specifically scientific or medical question about whether addiction is a disease.

Before going further with my critique, however, an important clarification must be issued. In relation to the specific syndrome of driven and unmanageable sexual behavior described by the diagnostic term “sexual addiction,” I will acknowledge that this condition is the focus of longstanding nosological controversy, which is reflected in a lively debate in the professional literature (e.g., Barth & Kinder, 1987; Goodman, 2001; Kafka, 2001; Shaffer, 1994). Whatever the nosological designation of the condition—sexual addiction (Carnes, 1983), sexual compulsivity (Coleman, 1987), nonparaphilic hypersexuality (Kafka, 2001) or otherwise—many professionals agree that such a syndrome of unmanageable sexual behavior does exist among a proportion of the general population and warrants some form of treatment due to its destructiveness. Having acknowledged the diagnostic debate, I will use the term “sexual addiction” in this article for the following reasons. First, sexual addiction appears to be the most common, and thus the most familiar, designation of the problem in the treatment literature. Second, since Peele also employs the term addiction, using it here is convenient for interacting with the debate between the illness and experiential-constructivist views of destructive patterns of sexual behavior and interpersonal attachments. Third, nosological distinctions of addiction, compulsivity, or otherwise, are quite

irrelevant to this article. Even though Peele appears to target the medical model of addiction, a broader reading of his writing (e.g., Peele, 1989) indicates that he is responding to the spirit of trigger happy psychiatric diagnostic labeling that (he argues) causes society to be full of “disease sufferers” in need of one form of treatment or another. Hence the question of nosology, though an important one, is not central to the analysis at hand.

The question of whether addiction is a disease is an important one for which the answer necessarily reflects philosophical understandings about the nature of persons, human agency, and spheres of moral responsibility. There are implied theological understandings as well if one embraces the central role and a specific concept of God in overcoming addiction. Of course, different answers to the question lend themselves to different beliefs surrounding treatment and recovery (e.g., whether it is at all possible to be an ex-addict as opposed to being always “in recovery”). The point is that as professionals who work with addicts, we should be honest that whether as humanists, agnostics, or people of faith, we interact with the theories and practices of our field through a framework of epistemological assumptions that we hold because of our worldview. Thus, as an evangelical Christian, I am acutely aware that I interact with the theories and treatment of addiction through my Christian belief system. That belief system has a major clinical role as well since I work with a predominantly evangelical client base at a Christian psychiatric practice. It necessarily informs how I view and utilize an inherently value-laden tool like the 12-steps, my understanding of which is informed by my particular value and epistemological framework.

Reading the 12-steps through an evangelical theological lens allows me to separate the 12-steps from the controversial ideology of addiction that dominates the treatment field. Thus I am able to embrace the 12-steps as a clinically useful tool without subscribing to the disease view of addiction. Furthermore, I believe that the 12-steps are meant to be understood “Christianly”—indeed I think something is lost if they are not—because of their explicitly Protestant evangelical roots. Originating as six principles of the Oxford Group, an interdenominational Christian organization, the 12-steps attained their current form when those six original principles were co-opted, elaborated, and given an ecumenical dimension by Alcoholics Anonymous (Stafford, 1991). The 12-steps of AA would then be adapted by every other 12-step group which replaced “alcohol” with the specific addiction in question. To understand the spirit of the 12-steps, it is important to know a little about the evangelical identity of the original Oxford Group, which was organized around the country as small groups emphasizing prayer, mutual confession, the importance of making restitution for one’s wrongs, and offering personal witness to others (Stafford, 1991). When the original Oxford principles were co-opted by and elaborated into the 12-steps of AA, they became inextricably linked to the ideology of the disease model because AA, even though it did not invent the disease model of alcohol addiction, certainly popularized it.

THE 12-STEPS UNDERSTOOD IN TERMS OF THE CHRISTIAN FAITH

The 12-steps originated out of the Christian theological framework of belief that a spiritually broken, sinful condition permeates all of human existence. Within this framework, humans are believed to be powerless against the unrelenting grip of sin but, paradoxically, endowed with free will that renders them fully morally culpable for the choices they make. Being fatally weakened against sin, then, is not an excuse to abdicate responsibility to fulfill one's moral potential. Christians believe that this effort is bound to fail, however, without exercising faith and dependence on God through Jesus Christ, who empowers the human will to change through the transforming and quickening power of the Holy Spirit; this is the distinguishing belief of Christianity. Faith calls for not merely a passive belief in some unknown being, but an active relationship with an intimate Creator that requires the exercise of choice and discipline, through which the will is gradually freed and sustained to do what on its own it is incapable of doing. While those with more humanistic viewpoints are likely to interpret the 12-steps as disempowering and limiting to people's ability to influence their destiny, Christians interpret the 12-steps very differently based on their theological understanding of sin, grace, and redemption. Again I wish to emphasize that my purpose here is not to pit one belief system against another, but to show, using the example of Christianity, that how one approaches a value-laden framework such as the 12-steps is necessarily influenced by the epistemological assumptions (whether implicit or explicit) of the worldview one endorses. Nevertheless, I would also argue that because of their Protestant roots, the 12-steps, notwithstanding the removal of overt Christian elements by AA, make the most sense only if understood against a Christian theological framework. Controversy unsurprisingly arises when the 12-steps are interpreted against more rationalistic or humanistic worldviews which entail a very different set of axiomatic positions about the nature of personhood.

The greater controversy arises because of the reality that the 12-steps are inextricably associated with the medical/disease model of addiction. As a major critic of this model, Peele (1989) argues that far from liberating the addict, the medical model stymies the human will from executing positive change and fosters even greater dependency on external structures. Although this was never what the 12-steps intended, I believe that Peele is right that the spirit of the medical model serves to diminish the human will's capacity to change and grow. When grave new social ills like lip balm addiction are identified, one can only wonder if the effect of groups like Lip Balm Anonymous (<http://www.kevdo.com/lipbalm>) has truly been the empowerment of the self, or the deepening of insecurity in a threatening world that fosters dependency on agents of change external to the self.

CONSTRUCTING AN ADDICTION: THE CASE OF SEX ADDICTION

With sex/love addiction now recognized as a disorder in its own right, disordered love has become significantly more than the metaphor that Peele and Brodsky used in 1975 to explore the nature of addiction. The diagnostic legitimacy that has been given to sex and love addiction now affords us the opportunity to explore their position as a *hypothesis*—that life experience and context help some addicts to construct their experience of addiction—against some clinical observations in our field. I wish to examine this hypothesis against the backdrop of my clinical interaction with two groups: (1) “Chaste sex addicts”—Evangelical young men who do not engage in partnered sex but have developed a compulsive relationship to solitary sex behaviors (e.g., masturbation and pornography use); and (2) Ego-dystonic homosexual and bisexual men who comprise the membership of Homosexuals Anonymous (HA) and Exodus International¹ groups. Although I offer some of my own empirical estimates (in the case of chaste addicts), my analyses are largely based on broad observations from my vantage point as a Christian therapist working with a religious demographic. Any conclusions I offer should therefore be held tentatively and critically in lieu of further empirical study. Nevertheless, I believe that my observations bear out Peele’s belief that addiction can be an experientially and socially constructed disorder.

Chaste Sex Addicts

Much of my professional work is dedicated to preventive work with young, early stage sex addicts who do not engage in partnered sex but have a compulsive relationship to masturbation and pornography use. I have written on the conceptual dilemmas raised by such “chaste sex addicts,” the limitations of existing diagnostic inventories such as the Sex Addiction Screening Test (Carnes, 1989) or the Sexual Compulsivity Scale (Kalichman & Rompa, 1995) to assess these individuals, and the inappropriateness of 12-step treatment given the youthfulness of these chaste addicts and the lack of progression in their behavior (Kwee, Dominguez, & Ferrell, 2007). Moreover, chaste sex addiction seems to be a peculiarly religious phenomenon affecting unmarried people of faith because of a religious value system that disapproves of pre-marital sex, that relentlessly promotes the ideal of “sexual purity” (while leaving this term unhelpfully vague), and that tends to engender false guilt around even developmentally normative dimensions of sexuality so that at-risk individuals do not feel safe to disclose problematic behaviors. The result

¹ Exodus International is the worldwide umbrella organization of disparate Protestant Christian ministries devoted to helping same-sex attracted individuals “recover” from homosexuality through spiritually mediated methods.

of this is that sexual struggles get pushed underground and, for some individuals, acquire an addictive dynamic due to a confluence of risk factors.

My task is made more complicated by the need to distinguish between true addicts (i.e., those whose relationship to pornography and masturbation may be classified as compulsive) and those who think they are sexually addicted but who have over-reactive guilt feelings to the normal dimensions of sexuality. A needs assessment at the Wheaton College Counseling Center found that over a two-year period, approximately 60% of male students who indicated that they were consulting a counselor because of sexual concerns believed or suspected that they struggled with sexual addiction due to unwanted thoughts, feelings or behavior, whether or not they were actually assessed to have an addiction (Kwee, Dominguez, & Ferrell, 2007). This finding is quite stunning given that the best estimates of the frequency of sexual addiction in the general population is just 3–6% (Carnes, 1991; Coleman, Miner, Ohlerking, & Raymond, 2001). We speculate that one socio-cultural explanation for this discrepancy may be the explosion of evangelical Christian literature on “sexual purity” that has occurred in parallel to the popularizing of the sexual addiction concept. With “sexual purity” a virtual catchphrase among abstinence-minded Christians and the sexual addiction concept holding a certain prominence in the pop psychology marketplace, it is not surprising to us that more and more Christians are wondering if their unwanted sexual appetites are the result of an addiction. Interestingly, there may be an analog to this in alcoholism. Peele (2000) reported:

At the time between the late 1960s and early 1980s when the concept of alcoholism became a heavily marketed cultural icon, drinking did not increase in the U.S. Nonetheless, [National Institute of Alcohol Abuse and Alcoholism] surveys revealed a sharp and significant upturn in those reporting symptoms of alcohol dependence (although not of ordinary drinking problems)—a rise that has not reversed itself since. Both in this historical phenomenon and [some epidemiological research findings], we see that thinking about addiction and about one’s behavior precedes and determines the addictive experience.” (p. 603)

Utilizing a cross cultural epidemiologic model, Peele (1997) helped to elucidate the last statement by showing that religious and cultural distinctions among Western nations predicted differential rates of behavioral and social problems associated with drinking. Among other things this study found an inverse relationship between alcohol consumption levels and the level of problems associated with loss-of-control drinking, as measured by the prevalence of AA groups. A “Temperance” versus “non-Temperance” cultural distinction appears to account for this relationship: Temperance cultures, which are largely Protestant societies that approach excessive drinking as a social ill, consume less alcohol overall but display significantly greater levels

of behavioral problems, reflected in AA group participation, associated with loss-of-control drinking. In non-Temperance societies where drinking is more integrated into the fabric of social and family life, alcohol use appears to be more behaviorally benign (Peele, 1997).

In treating sexual addiction among young Christian men, I have been compelled to reflect on Peele's hypothesis that "thinking about addiction and about one's behavior precedes and determines the addictive experience" (Peele, 2000, p. 603). I have co-developed *Single-Minded*, a structured preventive intervention for early stage sex addicts that is based on psychoeducation and emotionally focused therapy (EFT) principles (Kwee & Lepage, 2006).² EFT, which is an empirically supported (Dandeneau & Johnson, 1994; Denton, Burlison, Clark, Rodriguez, & Hobbs, 2000) treatment approach integrating the humanistic and family systems approaches, seeks to validate the client's constructed reality around his experience of emotions, and to tie these emotions into fundamental attachment needs which are affirmed as legitimate. Through the empathic and validating stance of the therapist, clients are helped to feel understood and to become ever more unafraid of their emotional experience, not least to use their emotions as a rich source of insight and information.

One method that we employ to understand the client's phenomenological experience of sexuality is to help the client to construct an eco-map (Hartman, 1978)—one that pertains to the sources of his beliefs and perceptions about sexuality. The client's "sexual eco-map," as we call it, helps him to tell his unique story of how he came to develop a compulsive relationship to masturbation and pornography. Several broad themes have emerged as we hear our clients relay their stories through their eco-maps. First, these religious young men come from family and church cultures that generally do not foster openness and safety in discussing sexuality. Misconceptions often prevail due to the stifling of honest dialogue, sweeping condemnations from the pulpit coupled with the elevation of inscrutable ideals (e.g., "modesty," "purity," etc.) and, in a surprising number of cases, the absence of sex education within the families. Second, clients describe through their eco-maps being hemmed in between a highly sexualized popular culture, and insular religious subcultures where sex is stigmatized and they do not feel safe to disclose problem behaviors. As a result, sexuality becomes split off into its own "eco-domain" wherein compulsivity in masturbation and pornography use are allowed to escalate by dint of not being dealt with. Third, unhealthy family dynamics and insecure attachments have contributed to a weakened

² As it is, *Single-Minded* employs the principles of EFT, a treatment approach used with couples and families, but because of its preventive focus and use with singles, it is not EFT *per se*. We liken our approach more to emotional skills coaching as we are seeking to educate clients on the adaptiveness of their emotions, and to use their emotions as the fulcrum for recognizing and validating needs and choosing adaptive behaviors in place of sexual coping.

capacity for emotional regulation whereby sexual coping becomes a routinized and dependable means to provide internal regulation and calming, consistent with the developmental model proposed by Schwartz and Southern (1999).

It appears that a confluence of the emotional environment, the lack of accurate information, and shame create the engine that drives the early stages of addiction, which I think bears out Peele's notion of addiction being experientially and contextually formed and not, therefore, a disease. Clinically speaking, I believe that this experiential-constructivist view of addiction engenders far more hope for the young addict than the disease model as it locates the client's healing in his capacity to relate with meaning and purpose to his environment, and to find significance through the integration of his many dimensions—emotional, sexual, intellectual, and relational—with all of these domains being meaningfully woven around rather than split off from his spiritual experience. For older, more progressed addicts, I still employ a 12-step approach which, as I have argued, is not inconsistent from a Christian theological standpoint with rejecting the disease view of sexual addiction. Yet I am wary of the *spirit* of the 12-steps as it is generally practiced today in secular addiction treatment, which perpetuates the view that addiction is a medical condition with its own inexorable course that can only be contained by the self-help structure. I do not believe that this view engenders hope and leads to empowerment, and so I have chosen to use the strengths-based language of prevention because the last thing early stage addicts—these unmarried young men who do not yet engage in partnered sex—need is the sticky label of “recovering sex addict.”

Homosexuals Anonymous/Exodus International

Homosexuals Anonymous (HA) and Exodus International (Exodus) are two extremely controversial organizations that believe that homosexuality is a spiritual and psychological disorder that can be reversed. As one who is acquainted with Exodus through research and personal contacts that have afforded me the opportunity to attend meetings, I am skeptical about this organization's claims of success in the absence of documented results from a controlled, longitudinal study—as opposed to methodologically weak cross-sectional or retrospective studies that have purported to show change (e.g., Nicolosi, Byrd, & Potts, 2000). It seems that it is impossible to have a reasonable and objective discourse about homosexuality when the issue is so politically charged these days. Notice the swift and condemning reaction to Spitzer's (2003) study purporting that some former gays and lesbians report change to heterosexuality (yet another retrospective, non-control group study with a self-selected sample), which elicited voluminous and highly charged responses in the well-respected and usually emotionally tempered human

sexuality journal in which it was published.³ Evidently, rational dialogue is rendered oxymoronic by the politically driven hyperbole and strong emotions on both sides of the topic of sexual orientation change.

Still more irrational are the pseudoscientific conversations about causation and change that occur within Exodus and HA. In Exodus ministries, participants often use the language of sexual addiction because their feelings and behavior are unwanted yet so intransigent, causing them to feel out of control. Far from being uniform, as commonly assumed, the approach of Exodus groups consists of a hodge podge of various healing philosophies and methods (Satinover, 1996; Yarhouse, Burkett, & Kreeft, 2002). While the methods are fairly diverse, they generally entail some form of group support, individual mentoring and accountability, prayer, and bibliotherapy, loosely resembling the approach of 12-step groups (Kwee, 2006). Much more overt and dogmatic in its adherence of addiction recovery principles in dealing with homosexuality is the organization called Homosexuals Anonymous (<http://www.ha-fs.org>) which, as its name suggests, employs the 12-step framework which it has co-opted from AA and modified into 14 steps. Although HA eschews the language of disease in its literature and website and the word "addiction" is nowhere to be found in its position statement, the organization's approach, which is borne out in its 14 steps, is clearly predicated on the belief that homosexuality is inherently compulsive.⁴ The empirical evidence for homosexuality being an addictive or compulsive disorder is of course entirely non-existent, but this has not stopped pseudoscientific formulations from being uncritically accepted as fact, such as an influential (within HA and Exodus) bio-developmental model that proposes that homosexuality develops along a multifactorial pathway that parallels the etiology of substance addiction and myriad paraphilic disorders.⁵ This scientifically unmerited model posits that homosexual behavior is a compulsion that is engaged in to provide self-soothing and anxiety reduction (Satinover, 1996).

What happens when individuals believe that their same-sex attractions are symptomatic of compulsions or an addiction? I believe that it can inform

³ Spitzer is especially notable for publishing this study given that he served on the American Psychiatric Association's task force which, in 1973, recommended the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders*. Spitzer has not reversed his position that homosexuality is not a disorder. He seems to be on an honest scientific quest unswayed by any religious agenda, yet for asking politically unpopular questions, he has gone from being lauded by the GLBT community to being accused of violating the Nuremberg Code of medical ethics for reinforcing the stigmatization and mental suffering of the GLBT community (Wainberg et al., 2003).

⁴ This is a position that makes complete sense only if one considers that heterosexuality is just as inherently compulsive for the straight person who wishes that he or she were not attracted to members of the opposite sex.

⁵ Among the paraphilic disorders to which the author likens homosexuality are: "Pedophilia, transvestic fetishism, paraphilic rape fantasies, compulsive paraphilic masturbation, cross dressing, and exhibitionism" (Satinover, 1996, pp. 192–193).

their thinking and behavior in two ways. First, some individuals will invariably frame their unwanted behavior as relapse and feel that because they cannot get better on their own, they need to surrender their lives to an external structure that will keep them in check. As Peele (1989) has argued, these structures can have the counterproductive effect of keeping people stuck by fostering helpless dependency through the belief that their “illness” will take an inexorable course unless contained by the structure. Second, the prospect of being gay can be so threatening to some individuals that they split their homosexuality off into behaviors that are addictive by any standard because of the rituals, secrecy, and hiding involved. These cycles of “relapsing” reinforce the belief among these individuals that they are sex addicts, thus also reinforcing their dependency on the self-help structure.

I am, of course, talking about denial—denial that is used to cope with the intense intrapsychic conflict of having ego-dystonic same-sex feelings, and which serves only to reinforce the view that these people are addicts because addiction, after all, is supposed to be a disease of denial. The consequences of denial can be seen in the painful dilemmas experienced in some mixed-orientation marriages, which are marriages in which one spouse is homosexual or bisexual, and the other spouse is heterosexual. I wish to illustrate from the case where the same-sex attracted spouse is the husband. The fact that male homosexuality is considered incompatible with and inferior to culturally based male gender stereotypes—a prejudice that is reinforced by organizations such as HA—may cause married same-sex attracted men to disavow and split off their homosexual identity into furtive sexual activity and to engage in the very types of behaviors that are considered to be evidence of a sexual addiction. Brownfain (1985) has argued that the inherent conflict of having forbidden and stigmatized homosexual desires while being a conventional, heterosexually married man leads to precisely the problem of secrecy and spousal deception. Such denial can have implications well beyond the stability of the marital unit. An influential field study on HIV infection risk (Earl, 1990) found that homosexually active married men who do not identify as gay or bisexual were actually at higher risk of contracting HIV and infecting their partners than self-identified gay or bisexual men. This study noted:

Married men appeared twice as likely to use more than one site for anonymous sexual encounters. They were nearly three times as likely to choose not to use a condom, and their spouses were more than twice as likely not to know about the high risk sexual behavior (when compared to the report of men who identified as gay and bisexual and were in a “serious relationship”). There was no statistical difference among preferred sexual behaviors. Married men were more likely to seek anonymous interaction. *Married men were more likely to consider being gay as a devalued or compromised identity.* (Earl, 1990, p. 256; italics added)

Thus, denial can have potentially fatal consequences for these men, their wives, and their unborn infants. While the purpose of the study was to argue for a refocusing of HIV education strategy from high-risk groups to high-risk behaviors, from the standpoint of reducing destructive addictive behaviors, it is impossible to ignore the importance of dismantling the powerful intrapsychic mechanism of denial. It is a sad reality that by being inimical to this objective, groups like HA thrive by contributing to an antithetical result—the perpetuation of addictive behaviors among ego-dystonic gay and bisexual men.

THERAPEUTIC CONSIDERATIONS

In part because of the relative nascence of the field of sexual addiction treatment, few question the lack of alternatives to standard 12-step intervention. To obtain an understanding of the relative efficacy of 12-step intervention, it may be particularly instructive to look at treatment outcome and meta-analytical studies comparing various modalities of treating alcohol addiction. According to a literature review by Peele, Bufe, and Brodsky (2000), little justification was found for the use of expensive, institutionalized 12-step treatment for alcoholism. The authors did summarize treatments that appear to demonstrate efficacy along with cost effectiveness: The best supported therapy, the Community Reinforcement Approach (CRA), addresses the multiple contextual factors (marital, family, social, and economic) that inform the development of alcohol abuse. CRA entails six core components: Communication skills training, problem solving skills training, help finding employment, encouragement of non-drinking relationships, recreational counseling, and marital therapy. Other interventions found to be effective were social skills training, behavioral marital/family therapy (which helps the non-abusing spouse give up futile, enabling behaviors and to reinforce sober behavior), brief intervention and motivational interviewing (interventions in which therapists help clients work towards personally meaningful goals consistent with their values) (Peele, Bufe, & Brodsky, 2000).

To suggest, however, that we can merely create analogs of alcoholism treatments for sexual addiction is a gross oversimplification because each condition entails different etiologies, behaviors, and risks. Thus, a hypothetical sex addiction analog of Moderation Management (<http://www.moderation.org>) cannot be recommended, even if MM were to work for some people with problem drinking, because we are not dealing with one behavior set (drinking, in the case of alcoholism) but polymorphous expressions of behavioral compulsivity with different associated risks and consequences. Some sexually compulsive behaviors are simply too dangerous to be maintained whatever the degree of moderation. Nevertheless, Peele et al.'s (2000) review of alcoholism treatment efficacy

does provide some clinically intuitive insights that can be applied to our field. I have couched these insights in the form of three broad treatment recommendations:

1. Treat each client as a unique bio-psycho-social phenomenon, with his or her own unique constructed reality, rather than as a sufferer of a disease that is independent from other contextual forces. This does not mean abandoning 12-step treatment. On the contrary, I have found the 12-step framework to be an ideal therapeutic platform for helping clients to become meaningfully embedded in life through an exploration of values, relationships, life purpose, and spirituality. Mere behavioral success cannot be divorced from the more ultimate question of what it means to be a successful human being.
2. Help the client to develop cognitive, social, and emotional skills for relating, communicating, and problem solving. Allow the client to consolidate these skills in the group setting and through conjoint therapy. Skills training appears to be part of a successful and far reaching recovery that will outlast the time spent in a treatment program.
3. Help clients to “buy into” their treatment by giving them a personal stake in the process. This is why motivational interviewing appears to be a successful intervention. I believe this is also why 12-step intervention appears to work for committed, faith-oriented individuals who view their recovery within a vastly bigger and intensely personal frame of spiritual salvation.

CONCLUSION

The experiential-constructivist hypothesis of addiction, which holds that context and socially based expectations about addiction shape the actual experience of addiction, is a view that is closely associated with Stanton Peele. In this article I have used this model of addiction as a vehicle to examine the nature of the condition that is most commonly known as sexual addiction. Peele and Brodsky (1975) first proposed the argument that addiction is experientially and contextually formed in their book *Love and Addiction*, which arguably is the first book to address what is now termed codependency. The authors used the construct of compulsive interpersonal attachment to examine the nature of substance addiction and to argue that, as opposed to being diseases with an inexorable course, disorders like alcoholism are shaped by existential insecurity and contextual forces that mold a compelling experience with mood altering substances. With the legitimacy that has been given to codependency and sex/love addiction as actual disorders warranting 12-step treatment, we can now directly explore this hypothesis in relation to sexual addiction. The cases of religious “chaste sex addicts” and Homosexuals Anonymous were used to illustrate how sex addiction may be constructed

by the individual's subjective experience, contextual demands, and cultural forces. Finally, having noted the caveat that sexual addiction and alcoholism are incomparable in some respects, broad treatment recommendations were developed based on insights from non-12-step interventions that appear to be effective in the treatment of alcohol addiction.

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