

PROBLEMATIC SEXUAL BELIEFS AND BEHAVIORS IN THE CHURCH:
A CONTENT ANALYSIS OF FAITH-BASED CURRICULA RELATED TO
EVIDENCE-BASED INTERVENTIONS

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ABSTRACT

Internet pornography use, sexual problems, and sexual addiction are problematic not only for society but also for the church. The religious community needs interventions that can effectively treat sexually addictive and non-addictive problems that do no harm to individuals. The purpose of this study was: (a) to examine five faith-based curricula available for use in churches to determine whether they include key evidence-based treatment (EBT) components found effective in treating sexual addiction, and (b) to determine whether these curricula differentiate between addictive versus non-addictive sexual behaviors. Because no known studies have been conducted to examine faith-based treatment (FBT) curricula for EBT key components, the research design for this study was a qualitative inductive content analysis. The results showed that all five FBT curricula include EBT key components but the FBTs varied in how many EBT components they contained. The results also showed that only one of the five FBTs differentiates between and offers different treatment approaches for addictive versus non-addictive sexual behaviors. The recommendations were that the FBTs should expand their curricula to incorporate more EBT components, implement assessment measures to distinguish between addictive versus non-addictive sexual behaviors, and provide approaches that differentiate between sexual addiction, non-sexual addiction, and moral/sin issues. With these added components, the FBT curricula can make a significant difference in helping the church deal with sexual addiction, which can also positively influence the spiritual climate in the church.

Key words: behavioral addiction, Internet pornography use, sexual addiction, faith-based treatments for pornography use/sexual addiction, evidence-based treatments, churches and pornography use.

Dedication

This dissertation is dedicated to my family who made it possible for me to complete this research study.

To my husband and best friend, Scott, I am very thankful for your constant support and encouragement. You believed in me, made sacrifices, and went the extra mile so I could complete this dissertation. You are truly my gift from God and the love of my life!

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List of Abbreviations

Behavioral Addiction (BA)

Brief Psychodynamic Therapy (BPT)

Cognitive Behavioral Therapy (CBT)

Compulsive Buying Disorder (CBD)

Evidence-Based Treatment (EBT)

Exercise Addiction (EA)

Faith-Based Treatment (FBT)

Gambling Disorder (GD)

Group Therapy (GT)

Internet Addiction (IA)

Love Addiction (LA)

Motivational Interviewing (MI)

Mindfulness-Based Cognitive Therapy (MBCT)

Sexaholics Anonymous (SA)

CHAPTER ONE: INTRODUCTION

On a global scale, pornography use has become increasingly widespread, and its use in Western cultures continues to grow, in part, because of easy and immediate access to the Internet (Price, Patterson, Regnerus, & Walley, 2016). The term *pornography* has been difficult to define because of the controversy and moral undertones linked to its meaning, but it commonly refers to “sexually explicit media (Internet sites, magazines, or movies) intended for sexual arousal” (Perry, 2017, p. 21). Additionally, the idea of sexual addiction, and more specifically pornography addiction, has been increasingly embraced by Americans over the past 30 years (Thomas, 2016), with more than 80% of young adult men and more than one-third of young adult women currently reporting that they use pornography regularly (Bradley, Grubbs, Uzdevaines, Exline, & Pargament, 2016; Carroll et al., 2008).

While the academic literature is split regarding whether pornography consumption can result in damaging effects to its users (Bradley et al., 2016), religious institutions strongly oppose pornography use (Patterson & Price, 2012). However, pornography use is not only found among the general population, but also exists within the religious community (Grubbs, Sessoms, Wheeler, & Volk, 2010; Grubbs, Volk, Exline, & Pargament, 2015). Research suggests that religious individuals experience distress over the discrepancy between their religious/moral beliefs and their behavior (Giordano & Cecil, 2014; Perry & Whitehead, 2018; Volk, Thomas, Sosin, Jacob, & Moen, 2016), and this distress may result in a perceived addiction to pornography (Bradley et al., 2016; Grubbs, Exline, Pargament, Hook, & Carlisle, 2015; Grubbs & Hook, 2016; Grubbs, Volk, et al., 2015; Thomas, 2016). In response, the church and various faith-based ministries have sought to deal with pornography use/addiction by approaching its

treatment from a Biblical perspective, which may or may not include evidence-based treatment (EBT) components that have been found to be successful in treating addictions.

Background of the Problem

Behavioral Addictions

Behavioral addiction (BA) is a behavioral sequence that has developed into a natural reward regardless of any potential negative consequences (Acharjee, Ahmed, & Shah, 2014). One of the core criteria for diagnosing psychoactive substance dependence and addiction is diminished control, and diminished control is also the main feature of non-substance, or “behavioral,” addiction (Grant et al., 2010).

The tremendous expansion of technology and continuous access to the Internet over the last 20 years have introduced a new set of reinforcing behavioral patterns that make some technology users more susceptible to technology-related habitual responses to stimuli. These habitual responses can develop into behavioral patterns in which some users experience diminished volitional control (Grant, Potenza, Weinstein, & Gorelick, 2010; Karim & Chaudhri, 2012). There is some controversy over how to classify behavioral addiction (BA), as some consider excessive behavioral patterns to be addictive behaviors, impulse control disorders, or obsessive-compulsive spectrum disorders (Fong, Reid, & Parhami, 2012; Marazziti, Presta, Baroni, Silvestri, & Dell-Osso, 2014), while others dispute the inclusion of most of these behavioral addictions as diagnoses (Karim & Chaudhri, 2012). BAs are often accompanied by the same symptoms found in substance abuse disorders but lack the physiological or medical withdrawal states (Grant et al., 2010). Further, research evidence increasingly shows that

substance and behavioral addictions both involve a disturbed reward system (Marazziti et al., 2014),

While it is well established that some individuals self-medicate with substances, it has also been hypothesized that self-medicating with behaviors shares similarities with substance addictions (Robbins & Clark, 2015). Behavioral self-medication occurs when an individual uses repetitive actions “to escape, numb, soothe, release tension, lessen anxiety or feel euphoric” (Karim & Chaudhri, 2012, p. 5). In their historical review of diagnosis patterns related to behavioral addiction in the clinical literature, Alavi and his colleagues (2012) note that mental health researchers began proposing behavioral addiction as a potential diagnosis in the latter part of the 20th century (Alavi, Ferdosi, Jannatifard, Eslami, Alaghemandan, & Setare, 2012). The behaviors in question included gambling disorder, Internet addiction, sexual addiction, exercise addiction, and compulsive buying disorder, all of which require further study (Robbins & Clark, 2015). Although gambling disorder is the only behavioral addiction currently listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychiatric Association [APA], 2013), behavioral addictions related to sexuality are becoming more prevalent and under stronger consideration for inclusion in future diagnostic manuals, due in part to the prevalence of developmentally inconsistent exposure to sexually explicit material (Riemersma & Sytsma, 2013).

Types of behavioral addictions. The range of excessive behaviors linked to addiction includes gambling, compulsive buying, exercise, love, Internet use, and sex. Chapter Two will provide a thorough overview of the available research on each of these excessive behaviors.

Gambling disorder. Gambling disorder (GD), a recurring gambling behavior that leads to significant distress, has been found to be like drug addiction in that it can include recurring failed

efforts to stop, irritable feelings when attempting to stop, and decreased ability to resist the urge to gamble regardless of the adverse consequences (APA, 2000; el-Guebaly, Mudry, Zohar, Tavares, & Potenza, 2011).

Compulsive buying disorder. Compulsive buying disorder (CBD), or excessive buying, is a controversial idea and many experts believe that for CBD to be diagnostically classified as an addiction, physical tolerance and withdrawal must be present (Karim & Chaudhri, 2012). Compulsive buyers indicate that buying relieves their escalating anxiety, yet it leads to negative emotions as a result of their shopping binges (Black, 2007; Karim & Chaudhri, 2012).

Exercise addiction. Exercise is a self-improving behavior, but it can also become addictive in a few individuals who excessively use physical exercise (Glasser, 2012; Weinstein & Weinstein, 2014). Often exercise is used as a coping skill for stress in people who exercise habitually (Szabo, 1995). In the clinical cases of exercise addiction (EA), individuals experienced significant loss of control over exercise behaviors that were performed out of obligation rather than enjoyment (Egorov & Szabo, 2013).

Love addiction. Love addiction (LA) involves a pathological emotional dependence on a partner that is possibly associated with separation anxiety (Marazziti, 2014). The partner becomes the individual's primary purpose for life, and the absence of the partner results in anxiety and discomfort for the individual (Reynaud, Karila, Blecha, & Benyamina, 2010).

Internet addiction. Internet addiction (IA), also referred to as "problematic" or "pathological" Internet use, has been described by several authors as the compulsive or extreme overuse of the Internet, resulting in negative consequences that affect an individual socially, occupationally, interpersonally, emotionally, and financially (Carlisle, Carlisle,

Polychronopoulos, Goodman-Scott, & Kirk-Jenkins, 2016; Jorgenson, Hsiao, & Yen, 2016; Karin & Chaudhri, 2012; Northrup, Lapierre, Kirk, & Rae, 2015; Weinstein & Lejoyeux, 2010).

Sexual addiction. Sexual addiction occurs when the instinctual drive for survival of the species becomes intensive and out-of-control (Rosenberg et al., 2014). The “classic” type is believed to be an attachment related problem (Schwartz & Southern, 2017) but the “contemporary” type results from overexposure to the continuously on and available Internet (Giordano et al., 2017; Riemersma & Sytsma, 2013).

Evidence-Based Treatments for Addictions

Gambling disorder. The EBTs for gambling disorder involve pharmacological treatments and psychological therapies including cognitive behavioral therapy (CBT), motivational interviewing (MI), and mindfulness-based therapy (MBT) (Acharjee et al., 2014; Yip & Potenza, 2014).

Compulsive buying disorder. The EBTs for compulsive buying disorder involve pharmacological treatments and psychological therapies including CBT, psychodynamic psychotherapy, and 12-step group therapy (Müller, Arikian, de Zwaan, & Mitchell, 2013).

Exercise addiction. No pharmacological treatments have been approved for the treatment of exercise addiction (Earp et al., 2017), and the psychological therapies that have been shown to be effective include CBT and contingency management (Acharjee, Ahmed, & Shah, 2014; Freimuth, Moniz, & Kim, 2011; Weinstein & Weinstein, 2014).

Love addiction. No pharmacological treatments have been approved for the treatment of love addiction (Marazziti et al., 2014). The psychological therapies suggested mainly involve group and couples therapy (Sussman, 2010).

Internet addiction. No pharmacological treatments have been approved for treating IA (Acharjee et al., 2014; Jorgenson et al., 2016). Some of the most widely used psychological treatments for IA include CBT (Acharjee et al., 2014; Carlisle et al., 2016; Jorgenson et al., 2016; Karim & Chaudhri, 2012; Young, 2011), MI (Carlisle et al., 2016; Jorgenson et al., 2016), and group counseling with CBT (Acharjee et al., 2014).

Sexual addiction. Pharmacological treatments have been found effective in treating sexual addiction when used along with psychotherapy. The best known psychological treatments for sexual addiction include CBT (Acharjee et al., 2014; Derbyshire & Grant, 2015; Fong et al., 2012; Garcia & Thibaut, 2010; Rosenberg, Carnes, & O'Connor, 2014), brief psychodynamic therapy (BPT) (Acharjee et al., 2014; Derbyshire & Grant, 2015; Garcia & Thibaut, 2010; Rosenberg et al., 2014), MI (Acharjee et al., 2014; Rosenberg et al., 2014), group therapy (GT) (Derbyshire & Grant, 2015; Fong et al., 2012; Garcia & Thibaut, 2010; Rosenberg et al., 2014), and MBCT (Fong et al., 2012; Reid, Bramen, Anderson, & Cohen, 2014; Witkiewitz et al., 2014).

Pornography Use, Sexual Addiction, and Religion

Numerous studies have examined the association between pornography and religion on a worldwide basis (Baltazar, Helm, McBride, Hopkins, & Stevens, 2010; Carroll et al., 2008; Doran & Price, 2014; Grubbs et al., 2015; Maddox, Rhoades, & Markman, 2011; Nelson, Padilla-Walker, & Carroll, 2010; Patterson & Price, 2012; Perry, 2017; Poulsen, Busby, & Galovan, 2013; Short, Kasper, & Wetterneck, 2015; Stack, Wasserman, & Kern, 2004). Generally, the basic teaching among many religions is that a monogamous, married, heterosexual relationship is the only appropriate context for sexual desires and behaviors (Perry, 2016; Reid, Carpenter, & Hook, 2016). Research suggests that people of faith experience distress when their

behavior and moral/religious beliefs do not align (Giordano & Cecil, 2014; Perry & Whitehead, 2018; Volk et al., 2016). For example, religious pornography users often experience profound guilt because they violate their core moral convictions regarding lust and masturbation (Baltazar et al., 2010; Grubb, Exline, et al., 2015; Grubbs & Hook, 2016; Nelson, Padilla-Walker, & Carroll, 2010; Perry & Whitehead, 2018). Such distress may lead them to perceive that they are addicted to pornography (Bradley et al., 2016; Grubbs et al., 2015; Grubbs & Hook, 2016; Grubbs, Volk, et al., 2015; Thomas, 2016).

Some researchers have suggested that individuals may interpret their normal behaviors as pathological based on their moralistic religious values (Clarkson & Kopaczewski, 2013; Goodson, McCormick, & Evans, 2000; Hald & Malmuth, 2008; Reid et al., 2016; Wilt, Cooper, Grubbs, Exline, & Pargament, 2016). Recent findings suggest that because individuals view their Internet pornography (IP) consumption as pathological, they connect their IP use with negative outcomes and perceive themselves to be addicted (Grubbs, Stauner, Exline, Pargament, & Lindberg, 2015; Grubbs, Volk et al., 2015). These findings suggest that IP use itself may be one of several factors contributing to the psychosocial distress related to IP use (Wilt et al., 2016).

Pornography/Sexual Addiction Treatments in Churches

In a study on the effects of pornography on church congregations, the Barna Group (2016) found that both males and females ages 13-24 have increased in pornography use, as compared to ages 25 and up. The 13-24 age group also are changing in their moral attitudes toward pornography and no longer see pornography as bad. However, the religious community overall views pornography use as morally wrong (Patterson & Price, 2012; Perry, 2015) and addictive (Grubbs, Exline et al., 2015). In response to the growing problem with IP use, churches are using curricula that focus on and encompass a wide range of sexual problems that are not

necessarily pathological (Volk, Moen, Thomas, Phillips, & Lashua, 2017). These curricula may or may not include the EBT components that have been shown to be effective in treating problematic IP use and sexual addiction.

Thus, when individuals seek help from the church for sexual behaviors that cause them distress, they may be misguided due to the religious community's misunderstanding of sexual behaviors and sexual addiction (Ferree, 2002). Many individuals are treated for sexual addiction when their behaviors are not, in fact, addictive, but are normal developmental behaviors that are simply inconsistent with their moral values (Grubbs, Exline et al., 2015). Those in the church who provide treatment may not have had proper training in how to deal with sexual addiction (Ferree, 2001, 2003; Volk et al., 2017), a contention that will be explored more fully in Chapter Two.

Problem Statement

Pornography use and sexual addiction are increasingly problematic for society in general as well as within the church. In religious communities, there is a need for sexual addiction treatment that is effective and does no harm to those seeking assistance in overcoming their unwanted sexual behavior. Evidence-based treatments (EBTs) have been shown to be effective in the treatment of sexual addiction; thus, the church needs to incorporate key components of EBTs into the treatments it provides for sexual addiction. Additionally, it is important for those providing treatment to distinguish between individuals who are sexually addicted and those who perceive themselves to be, but do not meet the criteria for sexual addiction.

Purpose of the Study

Although there is no official diagnosis for sexual addiction, pornography use and sexual addiction continue to be growing problems in society and in the religious communities. EBTs such as cognitive behavioral therapy (CBT), brief psychodynamic therapy (BPT), motivation interviewing (MI), group therapy (GT), and mindfulness-based cognitive therapy (MBCT) have been found to be effective in treating problematic sexual behaviors and sexual addiction. Additionally, religious communities have begun to establish treatment approaches to help church members deal with and resolve unwanted sexual behavioral patterns. These approaches typically integrate Biblical counseling and, potentially, some features of EBTs. These faith-based treatments (FBT) report on their websites that they are experiencing success in helping individuals deal with and overcome sexual addictions. Thus, the purpose of this study is to examine five FBT curricula that are available for use in local churches to determine whether they involve key components of EBTs, which could contribute to their success in treating sexual addiction. Additionally, this study seeks to determine whether these faith-based curricula differentiate between addictive versus problematic sexual behaviors.

Research Questions and Approach

The purpose of this study is to determine whether the key components of EBTs are included in the curricula of five faith-based treatments, and whether these faith-based curricula differentiate between addictive versus problematic sexual behaviors. In keeping with this purpose, the study seeks to answer two research questions:

1. Are faith-based organizations designing curricula for treating problematic pornography use, sexual problems, and sexual addiction that include the key components of EBTs?
2. To what degree are themes in faith-based ministry curricula for problematic sexual behaviors focused on non-addictive approaches? More specifically, do the current curricula differentiate between addictive and problematic sexual behavior?

This is the first known study to examine whether key components of EBTs are included in FBT curricula. There are no other studies from which to draw information or with which to compare this work. Thus, this study will conduct a qualitative inductive content analysis (QICA), an approach used when no prior studies exist on a phenomenon (Elo & Kyngas, 2007).

Bengtsson (2016) describes qualitative content analysis as “the process of developing conclusions from collected data by weaving together new information into theories” (pp. 9-10). Chapman, McLellan, and Tezuka (2016) describe this approach as a method that “allows for an organized, systematic analysis of text in order to reveal common elements, themes, and patterns within procedures, and to interpret and make observations of assessed, relevant data” (p. 4). This study uses the key components of each of the five top EBTs for sexual addiction as the coding framework, assessing each of the five FBT sexual addiction curricula relative to that framework. By exploring the use of particular words, phrases, and terms within each faith-based curriculum, this approach allows the researcher to determine whether and to what extent key EBT components are likely employed in each curriculum.

Limitations of the Study

The limitations of the study begin with the fact that there is no official *DSM-5* diagnosis or established diagnostic criteria for sexual addiction. Thus, the treatments may not be using the same criteria or targeting the same symptoms of sexual behavior, and symptoms may vary in severity and frequency. Further, the recommended EBTs for the treatment of sexual addiction are based on results of uncontrolled studies and case reports, rather than on randomized and controlled double-blind studies. Another limitation is the limited number of FBT approaches available to churches, which provides only a small sample of treatments for comparison.

Significance of the Study

The results of the study will be significant in that they will involve vetting the faith-based curricula to ensure the use of proper techniques and exercises for therapy. If the procedures and components used in these FBTs are not consistent with EBTs, there is no reason to consider conducting clinical studies on these treatments in the future. Conversely, if these FBTs are consistent with EBTs, then a greater opportunity may be available to establish the use of EBTs in churches with Biblically-based counseling programs. Therefore, the results of this study have the potential to help churches become more open to providing better mental health care.

Operational Definitions of Key Terms

Behavioral Addiction (BA)

Behavioral addiction is a relatively recent term that involves a compulsion to participate in a behavior that is non-drug related and rewarding (Acharjee et al., 2014). The main feature of

behavioral addiction is “the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others” (Grant et al., 2010, p. 234).

Brief Psychodynamic Therapy (BPT)

BPT is derived from the psychoanalytic theory. It examines childhood experiences and seeks to understand how those experiences have been interpreted and internalized during life. BPT looks at what is below the surface; that is, what motivates the individual’s thoughts and feelings. Freud explained that psychodynamic therapy involved “making conscious what has so far been unconscious” (Cabaniss, Cherry, Douglas, & Schwartz, 2011, p. 5).

Cognitive Behavioral Therapy (CBT)

CBT is an individual therapeutic approach that combines principles from cognitive therapy, behavioral therapy, and rational emotive therapy to examine patterns of thinking that result in self-destructive behaviors based on incorrect beliefs that drive thoughts (Young, 2009). It teaches individuals to identify and change thoughts that trigger sexually addictive feelings and actions, learn effective coping skills, and change their behavior.

Compulsive Buying Disorder (CBD)

CBD is an extreme preoccupation with buying/shopping. The excessive buying leads to distress and significantly interferes with social and work functioning (Karim & Chaudhri, 2012).

Evidence-Based Treatments (EBT)

EBTs are treatments and therapies that have been proven effective by research-based scientific and medical evidence.

Exercise Addiction (EA)

EA, such as running addiction (Weinstein & Weinstein, 2014), involves withdrawal symptoms of anxiety, guilt, depression, irritability, tension, and muscle twitching that occur

during times of running deprivation, and runners will continue to run despite injuries of other adverse consequences (Egorov & Szabo, 2013).

Gambling Disorder (GD)

GD, listed in the *DSM-5* under the heading “Substance-Related and Addictive Disorders, Non-Substance Related Disorder,” is a persistent/recurring problematic gambling behavior that leads to clinically significant impairment/distress. The individual must exhibit four or more *DSM-5* diagnostic criteria over a 12-month period to be diagnosed with GD (Yip & Potenza, 2014).

Group Therapy (GT)

GT is an effective therapeutic approach involving a small number of individuals, called group members, and one or more group therapists who are specially trained to facilitate group work (Brabender, Fallen, & Smolar, 2004). It is designed to encourage group members to improve psychologically by exploring the cognitive and affective interactions within the group environment, both among and between group members, as well as with the therapist(s).

Internet Addiction (IA)

IA has diagnostic criteria like GD but IA involves five of eight characteristic symptoms that include preoccupation with the Internet, tolerance, withdrawal, inability to control use, longer than intended use, functional distress, impairment, lying about use, and escape from problems (Ko, Yen, Yen, Chen, & Chen, 2012; Northup et al., 2015; Jorgenson et al., 2016).

Love Addiction (LA)

LA is defined as the point at which the desire for someone becomes a need, pleasure is replaced by suffering, and the individual continues in a relationship regardless of adverse consequences (Reynaud et al., 2010).

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT refers to maintaining a nonjudgmental awareness and acceptance of experiences in the present moment. It involves meditation techniques, breathing exercises, guided imagery, and other techniques that help the individual examine cognitive processes as they relate to triggers, urges, and cravings. MBCT has been defined as “the process of bringing awareness and acceptance to one’s moment-to-moment experience of thought, emotions, and bodily sensations in a nonjudgmental manner” (Bishop et al., 2004; Kabat-Zinn, 1990).

Motivational Interviewing (MI)

MI is a client-centered, directive intervention involving a collaborative effort between the therapist and client. It is designed to help clients resolve ambivalence about changing negative behaviors and increase their intrinsic motivation to change those behaviors (Miller & Rollnick, 2013). MI is a motivational conversation about change.

Pornography

The term *pornography* has historically been difficult to define because of the controversy and moral undertones linked to its meaning, but it commonly refers to “sexually explicit media (Internet sites, magazines, or movies) intended for sexual arousal” (Perry, 2017, p. 21).

Sexual Addiction

Individuals suffering from sexual addiction cannot control the cycle of thinking, feeling, and acting as it pertains to their sexual behaviors, and sex becomes their most important need (Carnes, 1989). Sexually addictive behaviors include compulsive affairs, masturbation, multiple sex partners, and various other socially unacceptable sexual behaviors (Carnes & Wilson, 2002; Karim & Chaudhri, 2012; Kor et al., 2013; Kraus et al., 2016).

Summary

Sexual problems and sexual addiction have become a problem not only in society at large but also in Christian churches. Some faith-based ministries have developed treatments that may be used in churches to help individuals struggling with pornography use, sexual problems, and sexual addiction, but it is unknown whether these treatments include EBT components. Chapter Two will present a detailed review of the research on behavioral addictions and on sexual addiction and its history, controversy, neurological causes, and prevalence, as well as the use of EBTs and FBTs in its treatment. The chapter will also address the Christian church's approach to dealing with pornography use, sexual problems, and sexual addiction among its followers.

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter begins with an overview of the literature on behavioral addictions, identifying the various types of behavioral addictions and providing a thorough review of existing research on sexual addiction. It examines the EBTs that have been identified as effective in treating sexual addiction and presents statistics on how the church is affected by pornography use and sexual addiction. The chapter concludes with a review of how the church and religious communities have attempted to deal with pornography use and sexual addiction among their members.

Behavioral Addiction

The term *addiction*, first used during Roman times, was derived from the Latin word *addicere*, which means “bound to” or “enslaved by” (Maddux & Desmond, 2000), and was not originally connected to substance use. *Behavioral addiction* is a relatively new term that refers to a compulsion to participate in a behavior that is non-drug related and rewarding (Acharjee et al., 2014). Behavioral addiction has been the focus of increasing attention in the mental health field over the last few decades (Marazziti et al., 2014). In 1975, Peele popularized the idea that true addictions can exist even when psychotropic drugs are absent. Noting that addicted persons are dependent on a specific set of experiences, Peele, along with other researchers, believed that addiction does not always have to involve the abuse of a chemical substance or intoxicant (Alavi et al., 2012).

Later, Marks (1990) introduced the construct of “non-chemical addictions,” leading to the endorsement of the term “behavioral addiction” by the field of addiction research and resulting in the establishment of a peer-reviewed journal (Billieux, Schimmenti, Khazaal, Maurage, &

Heeren, 2015, p. 119). Further, Holden's (2001) discussion of behavioral addictions highlighted the question of how best to conceptualize and classify addictions in both the *DSM-5* (APA, 2013) and the *International Classification of Diseases, 11th edition (ICD-11)* (World Health Organization [WHO], 1994) (Grant & Chamberlain, 2016; Potenza, 2014a). Although until recently popular belief held that addiction required a specific type of dependence on a drug or other chemical substance, experts in the field of behavioral science recognized that any source with the capacity to stimulate an individual could be addictive; thus, when a behavior changes from a habit into a compulsory action, the result can be viewed as an addiction (Alavi et al., 2012).

Over time, the term *addiction* increasingly became associated with substance use, especially around the time the *DSM-III-R* (APA, 1987) was published (Kor et al., 2013; Potenza, 2014a). The APA committee that dealt with substance-related disorders defined addiction as compulsive drug use (Kor et al., 2013; Potenza, 2014a). However, the term *addiction* was omitted from the *DSM-III-R* (APA, 1987) due to its charged nature and complexities (O'Brien, Volkow, & Li, 2006). The *DSM-IV-TR* (APA, 2000) included the category "Substance-Related Disorders," which was replaced in the *DSM-5* (APA, 2013) by the category "Substance-Related and Addictive Disorders" (Potenza, 2014a).

After the publication of the *DSM-IV* (APA, 1994), considerable research examined disorders such as gambling, substance use, and related conditions (Potenza, 2014a). As a result of this research, the APA decided to remove gambling disorder, formerly called compulsive gambling, from its *DSM-III* classification of "Impulse Control Disorders" (APA, 1987) and group it with "Substance-Related and Addictive Disorders" in the *DSM-5* (APA, 2013) (Robbins & Clark, 2015). Decades of empirical research on gambling disorder provided clinical, genetic,

neurobiological, and phenomenological data to support its similarities with substance addictions (Grant & Chamberlain, 2016). Thus, the renaming of “pathological gambling” to “gambling disorder” in the *DSM-5* (APA, 2013) represented a major step in recognizing behavioral addictions as psychiatric diagnoses and aligning them with other addictive behaviors. To date, addiction has been linked to a range of excessive behaviors, including “gambling, video game playing, eating disorders, sports and physical exercise, media use, sex, pathological working, and compulsive criminal behavior” (Alavi et al., 2012, p. 291).

Currently, gambling disorder (GD) is the only behavioral addiction recognized in the *DSM-5* (APA, 2013) and is listed in the new Non-Substance-Related subsection included at the end of the section on Substance-Related and Addictive Disorders. However, there is widespread interest in behaviors such as “Internet addiction, sexual addiction, compulsive shopping, and food as an addiction” (Robbins & Clark, 2015, p. 66). These conditions were not included along with gambling disorder due to the lack of peer-reviewed evidence at the time of the publication of the *DSM-5* (Potenza, 2014).

However, excessive Internet gaming was identified in the *DSM-5* (APA, 2013) as a condition requiring further study (Potenza, 2014a). The *DSM-5* provides the following explanation of the new Non-Substance-Related subsection:

In addition to the substance-related disorders, this chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to those produced by substance use disorders. Other excessive behavioral patterns, such as Internet gaming, have also been described, but research on these and other behavioral syndromes is less clear. Thus, groups of repetitive behaviors, which

some term *behavioral addictions*, with such subcategories as “sex addiction,” “exercise addiction,” or “shopping addiction,” are not included because at this time there is insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders. (APA, 2013, p. 481)

Behavioral Addiction Operationalization

The concept of addiction is difficult to define and is considered controversial (Alavi et al., 2012). An essential feature of behavioral addiction is “the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others” (Grant et al., 2010, p. 234). Excessive behavioral patterns are categorized by some as addictive behaviors, while others classify them as impulse control disorders or obsessive-compulsive spectrum disorders (Fong et al., 2012).

Behavioral addiction implies a type of reinforcement that results from performing a specific behavior; thus, it is behavior performed for its own sake (Robbins & Clark, 2015). However, data is needed to determine whether some/any of these behaviors are valid diagnoses. Behavioral addictions are frequently preceded by feelings of tension or arousal prior to performing the act followed by the experiencing of relief, pleasure, or gratification during and immediately following completion of the behavior (Grant et al., 2010). Many report an urge/craving just before beginning the behavior, and a decrease in anxiety and “high” mood state while engaging in the behavior (Grant et al., 2010, p. 234).

However, a decrease in the positive mood effects often occurs after repeated behaviors, with an accompanying need to increase the strength of the behavior to achieve the same level of effect, which is equivalent to tolerance (Grant et al., 2010). Many experts believe behavioral addictions can be active (e.g. playing video games) or passive (e.g. watching television) contain

features that are inducing and reinforcing, which lead to the development of addictive tendencies (Alavi et al., 2012). Unlike substance withdrawal, behavioral addictions lack reports of severe physiological or medically serious withdrawal states (Grant et al., 2010). Yet according to Young (1998), persons with behavioral addictions display specific symptoms and experience consequences similar to those resulting from alcohol/drug addiction and obsessive behaviors.

If specific behaviors are identified as addictions, it is reasonable to expect that those behaviors will respond with efficacy to the same treatments as substance disorders. Thus far, gambling disorder has shown the most convincing evidence, in that it appears to respond positively to specific opioid medications and glutamate-modulating agents (Barnes, Welte, Hoffman, & Tidwell, 2010; Bullock & Potenza, 2012; Clark & Limbrick-Oldfield, 2013; el-Guebaly, Mudry, Zohar, Tavares, & Potenza, 2012; Grant, Kim, & Potenza, 2003; Lupi et al., 2014; Marazziti, Presta, Baroni, Silvestri, & Dell'Osso, 2014; Yip & Potenza, 2014). Currently, researchers stress that a diagnosis of behavioral addiction can be made if functional impairments are present in social relationships and/or social situations and at work (Grant & Chamberlain, 2016).

Although behavioral addictions do not involve chemical intoxicants or substances, some researchers posit that behavioral addiction and chemical/substance addiction share some similar core indicators (Alavi et al., 2012; Grant et al., 2010; Clark & Limbrick-Oldfield, 2013) with respect to their natural history, phenomenology, and adverse consequences (Grant et al., 2010). They also share common core clinical features such as repetitive/compulsive participation in behavior regardless of adverse consequences; decreased control over the problematic behavior; urge/craving before engaging in the problematic behavior; and a pleasant experience while performing the behavior (Grant, Brewer, & Potenza, 2006). Evidence also supports that impulse-

control disorders and substance use disorders have similar features of tolerance, withdrawal, repeated failed attempts to decrease or stop, and major life functioning impairments (Grant et al., 2006).

Impulse control disorder behaviors may be conceptualized as an imbalance between an overstimulated drive state, an impairment in inhibition or reward processing, or a combination of these factors. 5-HT's dysfunction in impulse-control disorders may reflect the impairment in frontal inhibition which prevents individuals from controlling their desires. (Grant et al., 2006, p. 925)

Both types of addiction have natural histories that may show chronic and relapsing patterns and involve onset during adolescence and young adulthood; both also have a higher incidence among these age groups than among older adults (Grant et al., 2010). According to Davis (2001), behavioral addictions lack the physical signs of drug addiction, yet because of similarities neurobiologically, it is hypothesized that behavioral and substance-related addictions are comparable. Patients who suffer from behavioral addictions report addiction-specific circumstances and diagnostic criteria, including cravings, excessive behavior, loss of control, psychological/physical withdrawal symptoms, and increased tolerance (Alavi et al., 2012).

Types of Behavioral Addictions

A range of excessive behaviors have been linked to addiction, including gambling, compulsive buying, exercise, love, Internet usage, and sex. In the following section I will briefly define and discuss each of these excessive behaviors and identify the EBTs recommended for each. Given the tremendous growth of the Internet and the increase in online sexual behaviors, I will examine sexual addiction in more detail, and explore how the Christian community has attempted to deal with and resolve pornography use, sexual problems, and sexual addictions.

Gambling Disorder

Gambling disorder (GD) is characterized by persistent/recurring problematic gambling behavior that leads to clinically significant impairment/distress when the individual exhibits four or more *DSM-5* diagnostic criteria over a 12-month period (Yip & Potenza, 2014). It is listed in the *DSM-5* as a Non-Substance Related Disorder. The classification reflects the similarities both clinically and neurobiologically between GD and substance-related addictions, as well as a change in diagnostic criteria from the *DSM-IV* to the *DSM-5*.

The number of required criteria for a diagnosis of GD has changed from five to four, and the criteria “commission of gambling-related illegal acts” has been eliminated (Yip & Potenza, 2014). GD has been found to be similar to drug addictions in that it can include recurring failed efforts to control, reduce, or quit gambling; restless and/or irritable feelings when endeavoring to reduce or quit gambling; and decreased ability to resist an urge to gamble regardless of adverse consequences that result from the gambling behaviors (APA, 2000; el-Guebaly, Mudry, Zohar, Tavares, & Potenza, 2011).

Neurologically, multiple systems of neurotransmitters are involved in both GD and substance addiction. Dopamine is involved in motivation, learning, and rewards, while serotonin (5-HT) is involved in behavioral inhibition (el-Guebaly et al., 2011). Neuroimaging data suggest a common neurocircuitry for behavioral and substance addictions. Cravings in both behavioral and substance addictions have been linked to decreased activation in the ventral striatal, which has been also found in reward processing of simulated gambling in GD and alcoholism. Neuroimaging data has shown diminished activation of the frontostriatal circuitry, which contributes to impulsive decisions in GD and substance addictions (el-Guebaly et al., 2011). These brain areas, especially the ventromedial prefrontal cortex, seem to relate specifically to

measures of executive function linked to attention, planning, learning/reversal learning, attending, and decision-making (Potenza, 2014b).

The lifetime prevalence rates in the general population for gambling disorder range from 0.4% to 2.0%, the incidence of problem gambling ranges from 1.3% to 2.3%, and approximately one-third of pathological gamblers recover without therapy (Rash & Petry, 2014). The EBTs involve pharmacologic treatments and psychological therapies (Acharjee et al., 2014). There are no FDA-approved pharmacologic treatments for GD, but research suggests the limited efficacy of selective serotonin reuptake inhibitors (SSRIs), lithium, mood stabilizers, dopaminergic pharmacotherapies, opioidergic pharmacotherapies, glutamatergic pharmacotherapies (Yip & Potenza, 2014), antidepressants, and atypical antipsychotics (Marazziti et al., 2014). Psychological/behavioral therapies for GD focus on reducing GD-related symptoms. The results from meta-analytic data suggest that CBT, MI, MBT, behavioral therapies (imaginal desensitization), Gamblers Anonymous/12-step group-based therapies and combined behavioral/pharmacotherapy may be effective in treating GD (Acharjee et al., 2014; Yip & Potenza, 2014).

Compulsive Buying Disorder

Compulsive buying disorder (CBD), or “oniomania,” comes from the Greek word *ōnios* meaning “for sale” (Marazziti et al., 2014) and refers to an extreme preoccupation with buying/shopping. As with other behavioral addictions, CBD is a controversial idea and many experts believe that to be diagnostically classified as an addiction, there must be physical tolerance and withdrawal (Karim & Chaudhri, 2012). Although the definition of CBD varies, experts define it as a disorder “associated with compulsive thoughts or impulses to purchase unnecessary or large amounts of items despite its negative consequences” (Karim & Chaudhri,

2012, p. 11). This excessive buying leads to distress and significantly interferes with social and work functioning. Currently, there is no consensus among experts as to how to classify CBD, which is viewed as either an addictive disorder, impulse-control disorder, obsessive-compulsive spectrum disorder, or part of a larger psychiatric disorder, such as bipolar disorder or major depressive disorder (Fong et al., 2012).

Compulsive shoppers indicate that the rewarding feelings of compulsive shopping come from buying, planning, hunting, bargaining, and returning the item for future credit (Fong et al., 2012; Rose & Dhandayudham, 2014). Psychologically, they soothe conflict and tension by acquiring material possessions that they think will make them complete, but instead, those possessions lead to anxiety and depression (Fong et al., 2012). There is no comprehensive explanation for CBD, but Fong et al. (2012) found that compulsive shoppers seem to be impulsive buyers rather than bipolar or obsessive-compulsive. Further, compulsive shoppers frequently meet criteria for mood disorders, anxiety disorders, substance use disorders, and eating disorders (Black, 2007).

According to epidemiological reports, compulsive buying is generally chronic or intermittent (Karim & Chaudhri, 2012) and has an approximate 2% to 8% prevalence in the United States (Claes, Bijttebier, Mitchell, de Zwaan, & Mueller, 2011). CBD has an age of onset that generally ranges from 18- to 30-years-old; most of these individuals with CBD report incomes below \$50,000 (Black, 2007, 2012; Karim & Chaudhri). This group has high rates of comorbidity with depression and antisocial behaviors and has an increased risk of substance abuse (Fong et al., 2012). The gender ratio is mixed, with the ratio estimated by some to be nine (female) to one (male) (Claes et al., 2011), while others report approximately equal representation of both genders (Koran, Faber, Aboujaoude, Large, & Serpe, 2006).

The EBTs for CBD involve pharmacological interventions and psychotherapies (Fong et al., 2012). Pharmacological treatments include antidepressants, mood stabilizers, and opioid antagonists. Effective psychological therapies include CBT, cognitive behavioral group therapy, BPT, exposure and response prevention therapy, marriage and couples counseling, and 12-step group therapy (Müller et al., 2013).

Exercise Addiction

Physical exercise is a behavior that can be both mentally and physically therapeutic and beneficial (Egorov & Szabo, 2013). Glasser (2012) pointed out that certain self-improving behaviors, such as exercise, can become addictive, but in the process, they build a person's strength and promote a healthier, happier lifestyle. However, while committed forms of exercise might be therapeutic, loss of control leads to pathogenic behavior (Egorov & Szabo, 2013).

The concept of running addiction was first introduced by Sachs and Pargman (1984; Weinstein & Weinstein, 2014) to describe withdrawal symptoms of anxiety, guilt, depression, irritability, tension, and muscle twitching that occurred during times of running deprivation. Addicted runners were found to continue to run despite adverse consequences that should have reduced or interrupted their training (Egorov & Szabo, 2013). These clinical cases of exercise addiction were marked by loss of control over the exercise behaviors, which were carried out due to obligation rather than performed for enjoyment.

Additionally, these individuals displayed negative psychosocial and physical consequences of addictive disorder symptoms such as salience, tolerance, withdrawal, relapse, conflict, and mood modifications (Szabo, 2010). Exercise may be used as a skill to cope with stress among people who exercise excessively (Szabo, 1995), and research suggests that reward and motivation circuitries embedded in the limbic brain regions control the auto-regulation and

endogenous processing of stress (Weinstein & Weinstein, 2014). Weinstein and Weinstein also say that exercise and other physical activity may decrease psychological distress via pleasure induction by triggering endogenous opiates; these molecules and mechanisms reduced stress in animal research.

Actual diagnosed cases of exercise addiction have been rare and reported prevalence rates have been inconsistent, ranging from 0.3% to 6.9% (Egorov & Szabo, 2013). Four phases have been identified in exercise addiction (EA): 1) *recreational exercise*, an enjoyable and rewarding exercise experience; 2) *at-risk exercise*, in which exercise is intrinsically rewarding; 3) *problematic exercise*, where an individual's day is organized around an exercise routine that is becoming more and more rigid; and 4) *exercise addiction*, wherein the exercise behavior becomes the main organizing principle in life (Freimuth et al., 2011). It has been suggested that EA has an obsessive-compulsive dimension and rewarding features, leading some experts to suggest that it should be classified as a behavioral addiction (Weinstein & Weinstein, 2014). The literature on EBTs for exercise addiction is scant, but CBT and contingency management have been shown to be effective (Acharjee et al., 2014; Freimuth et al., 2011).

Love Addiction

Anthropologists have found descriptions of passionate love throughout history and across all cultures (Reynaud et al., 2010). Love passion typically occurs 3-5 times in a lifetime, continues for a few weeks to several years, is reversible, and has the potential of being re-experienced with another love object, all of which distinguish it in key ways from drug addiction. In the initial stages of a loving relationship, "a certain degree of dependence and desire to merge with the partner should be considered normal" (Marazziti et al., 2014, p. 7), but these dynamics tend to fade and disappear with time.

The move from normal love to addiction may be barely noticeable, as addiction is defined as the point at which desire becomes a need, pleasure is replaced by suffering, and the individual continues in the relationship regardless of adverse consequences (Reynaud et al., 2010). Pathological emotional dependence involves a continuation of or increase in the merging desire (Marazziti et al., 2014, p. 7). Possibly due to separation anxiety, the dependent individual is totally devoted to the partner and the partner's well-being, while neglecting their own needs. The partner becomes the individual's primary purpose in life and the object of desires and thoughts (Marazziti et al., 2014; Reynaud et al., 2010). The partner's absence produces anxiety and discomfort in the individual (Marazziti et al., 2014), who may experience extremely strong emotional lability and mood swings, depending on the love object's availability (Reynaud et al., 2010).

The stronger the love, the more violent the arousal of emotions. When the individual's feelings are reciprocated, a feeling of euphoria results; when those feelings are not returned, it can be perilous (Earp et al., 2017). If the relationship comes to an unwanted end, the individual will feel pain, grief, loss, and even depression and/or withdrawal from society. The individual can become distracted, unreasonable, unreliable, unfaithful, and even worse, deadly (Earp et al., 2017). In 2011, the number of murders committed in the United States by a victim's lover was over 10% (Federal Bureau of Investigation [FBI], 2011). Little is known about the prevalence rates.

Numerous studies have been published over the past decade on the neurobiology and neurochemistry of romantic love (Earp et al., 2017). These studies suggest that "being in love" is intimately linked to characteristic biochemical reactions within the brain involving dopamine, oxytocin (OT), vasopressin, and serotonin, which influence brain regions involved in the

development of trust, the formation of pleasurable feelings, and signals of reward (Burkett & Young, 2012; Esch & Stefano, 2005). These same neurochemicals and their activities have been well established in their associations with addiction. Mating and addiction elicit very similar dopamine activity concentrated in the brain's reward circuitry (Earp et al., 2017). Further, Earp et al. (2017) say that sex, orgasm, and all drugs of abuse stimulate the release of high levels of dopamine concentrated in the nucleus accumbens; dopamine is associated with many other processes involved with learning rewards. The responsiveness of the OT/vasopressin system is linked to attachment in humans, and the noradrenergic pathways are linked to sexual desire, attention, memory, and awakening (Reynaud et al., 2010). Additionally, Reynaud et al. (2010) found that major interactions that occur between the oxytocinogenic and serotonergic pathways are also linked to sexual desire.

There is no known data on pharmacological treatment and no approved medication for the treatment of love addiction, but clinical impressions recommend antidepressants and mood stabilizers (Marazziti et al., 2014). The psychological therapies suggested are group therapy, MI, 12-step organizations, individual or couples therapy, and self-help books (Sussman, 2010).

Internet Addiction

Internet addiction disorder (IA) was first introduced in 1996 at the Annual Meeting of the APA in Toronto, Canada (Young, 1998). IA, also referred to as “pathological Internet use” and “problematic Internet use” (Ko et al., 2012), has been described by several authors as the compulsive or extreme overuse of the Internet, resulting in negative consequences that affect an individual socially, occupationally, interpersonally, emotionally, and financially; interfere with one's physical health and sleep; and lead to impairment or distress (Carlisle et al., 2016; Jorgenson et al., 2016; Karin & Chaudhri, 2012; Northrup et al., 2015; Weinstein & Lejoyeux,

2010). The criteria for IA resemble the criteria for impulse-control disorder and/or substance dependence (Carlisle et al., 2016). Young (2004) adjusted the *DSM-IV* (APA, 2000) diagnostic criteria for pathological gambling to construct diagnostic criteria for IA (Ko et al., 2012; Northrup et al., 2015), which involve at least five of eight characteristic symptoms of pathological Internet use: preoccupation with the Internet, tolerance, withdrawal, inability to control use, longer use than intended, functional distress/impairment, lying about use, and using the Internet to escape from problems (Ko et al., 2012; Northrup et al., 2015; Jorgenson et al., 2016). Phenomenologically, IAs seem to have a minimum of three subtypes: excessive gaming, sexual preoccupations (cybersex), and email/text messaging (Weinstein & Lejoyeux, 2010). Further, Weinstein and Lejoyeux (2010) report that addicted individuals tend to engage in Internet use for extended periods of time, focusing entirely on the Internet activity while separating themselves from other means of social contact.

Diagnostic criteria and prevalence for Internet Addiction. A diagnosis of IA continues to be problematic, as there is no official diagnostic system, no widely accepted diagnostic criteria, and no IA diagnostic instruments that show suitable reliability and validity across the various countries in which they were tested (Weinstein & Lejoyeux, 2010). Studies on Internet addiction originally started in the United States (Young, 2013), but other countries, such as Italy, China, Korea, Turkey, Greece, and Norway, soon found similar problems occurring (Ko et al., 2012; Young, 2013). In recent years, both Western and Eastern societies have reported IA among the adult and adolescent populations, identifying it as an important mental health problem (Ko et al., 2012).

This increased concern regarding IA results from the fact that from 2007 to 2010, the number of global Internet users almost doubled, rising from 1.11 billion to 1.97 billion, and the

number escalated to 3 billion by the end of 2014 (Carlisle et al., 2016). In the U.S., the number of high-speed Internet lines has increased from 2.8 million in 1999 to 206 million in 2011, making the Internet widely accessible to most of the population. Online surveys in the U.S. and Europe suggest that IA prevalence rates range from 1.5% to 8.2%, while Asian countries appear to have higher prevalence rates ranging from 12.3% to 18.8% (Jorgenson et al., 2016; Ko et al., 2012; Sussman, Lisha, & Griffiths, 2011). The true IA prevalence in the U.S. is unknown (Karim & Chaudhri, 2012), and the reason for the higher rates in Asian countries is unclear (Jorgenson et al., 2016).

Although a variation of Internet addiction was included in *DSM-5* section 3, several authors have noted that the Internet is a medium and questioned whether individuals can become addicted to the *medium*, as opposed to the *process* facilitated by the medium (Carlisle et al., 2016; Northrup et al., 2015). The term “process” refers to *process addictions*, or “systematic behaviors mimicking the disease of addiction” (Wilson & Johnson, 2013). Process addictions are compulsive-like behaviors that are linked to urges and cravings that interfere with social and occupational functioning. They are pleasurable perceived, although they alter one’s individual mood and result in dependence (Carlisle et al., 2016). Like the effects of addictive substances, the pleasurable feelings from these behaviors (i.e., Internet gaming addiction, sex addiction, online auctions, social media, and shopping) hijack the brain’s reward system and change cognitive functioning (Carlisle et al., 2016).

The EBTs for IA involve a multimodal treatment approach. No medications have been approved for IA treatment, but bupropion and methylphenidate have shown promise (Acharjee et al., 2014; Jorgenson et al., 2016), and naltrexone added to an SSRI medication routine has yielded a decline in symptoms (Karim & Chaudhri, 2012). The most widely used psychological

treatments for IA involve CBT (Acharjee et al., 2014; Carlisle et al., 2016; Jorgenson et al., 2016; Karim & Chaudhri, 2012; Young, 2011), MI (Carlisle et al., 2016; Jorgenson et al., 2016), a six-week group counseling group program with CBT, social competence training, self-control strategies training, communication skills training (Acharjee et al., 2014), reality therapy (Acharjee et al., 2014; Carlisle et al., 2016), acceptance & commitment therapy (ACT) (Acharjee et al., 2014), CBT-IA (Acharjee et al., 2014; Jorgenson et al., 2016; Young, 2013), and the reSTART program, an inpatient IA program that combines CBT, ACT, brain-enhancing interventions, animal-assisted therapy, MI, Mindfulness-Based Relapse Prevention (MBRP), Mindfulness-Based Stress Reduction (MBSR), interpersonal group psychotherapy, individual psychotherapy, experiential adventure-based therapy, drug and alcohol treatment, 12-step work, individualized treatment for comorbid disorders, psychoeducation, and continuing outpatient treatment (Casha, Raea, Steela, & Winkler, 2012).

Sexual Addiction

Background

Sexually addicted behavior has occurred throughout history and is recorded in various ancient texts (Riemersma & Sytsma, 2013). It has been called by many different names, including *satyriasis* in men (Bigelow, 1859), *nymphomania* in women (Ellis & Sagarin, 1965), and *hyperesthesia* (von Krafft-Ebing, 1892). Benjamin Rush (1812), a physician who was also one of the U.S. founding fathers, clinically documented excessive sexual behaviors in his book, *Medical Inquiries and Observations upon the Diseases of the Mind* (Kafka, 2010; Karila et al., 2014; Rosenberg et al., 2014).

In the late 1800s and early 1900s, German psychiatrist Richard von Krafft-Ebing, who worked with patients he described as hyperesthesia sexual, presented the first case that indicated

abnormally increased sexual desire and contended that pathological sexuality is a genuine psychiatric illness (Garcia & Thibaut, 2010; Karila et al., 2014; von Krafft-Ebbing, 1886/1965). In the 1950s, Eisenstein (1956) observed numerous case studies in which hypersexual behavior progressed and developed into an addiction. In the mid-1970s, Orford, a British psychologist, first conceptualized sexual dependence as an excessive nonparaphilic sexual behavior and argued that the spectrum of addictive disorders should include hypersexuality (Orford, 1978; Karila et al., 2014).

Patrick Carnes (1983) first popularized the concept of sexual addiction in his landmark book, *Out of the Shadows: Understanding Sexual Addiction*, in which he suggested that sexual addiction was a psychopathological condition (Karila et al., 2014). Later, Kinsey conducted scientific studies of activities conventionally expected to belong in a married couple's bedroom, normalizing and naturalizing those activities (Griffiths, 2012). Kinsey's studies opened new paths for studying sex and brought the subject into general day-to-day conversation. In the late 1990s and early 2000s, numerous studies investigated sexual behavior on the Internet (Cooper et al., 2000; Griffiths, 2012).

Sexual Addiction Operationalization

Sex is essential to the survival of the species and requires not only an instinctual drive, but also a reward-based reinforcement to ensure the continuation of the species (Frascella, Potenza, Brown, & Childress, 2010). However, when the drive gets intensive and sexual activity becomes out-of-control, without regard for negative consequences, risks, or interference with non-sex-related tasks, this instinctual drive becomes addictive (Kor et al., 2013). Sexual addiction is defined as “a maladaptive pattern of sexual behavior, leading to clinically significant impairment or distress” (Rosenberg et al., 2014, p. 85) that involves “difficulties in controlling

inappropriate or excessive sexual fantasies, urges/cravings or behaviors that generate subjective distress or impairment in one's daily functioning" (Kraus et al., 2016).

Thus, sexual addiction, also called *compulsive sexual behavior*, *hypersexuality* (Karim & Chaudhri, 2012), *excessive sexuality*, and *problematic sexual behavior* (Derbyshire & Grant, 2015; Hall, 2014), is an individual's enormously strong sex drive or obsession with sex, which Seegers (2003) operationally defines as "a pathological relationship with a mood-altering experience" (p. 247). Individuals with sexual addiction are unable to say no to sex or to choose or control their thoughts, feelings, and actions regarding their sexual behaviors; sex becomes the addict's most important need (Carnes, 1989). Sexually addictive behaviors include compulsive affairs, masturbation, use of prostitutes, multiple sex partners, pornography use, cybersex, voyeurism, exhibitionism, sexual offending, and sexual harassment (Carnes & Wilson, 2002; Karim & Chaudhri, 2012; Kor et al., 2013; Kraus et al., 2016).

Sexual addiction is a controversial subject, and caution should be used in diagnosing sexual addiction or related disorders (Rosenberg et al., 2014), as all non-traditional sex-seeking behavior is not addictive or even problematic (Riemersma & Sytsma, 2013). Among those individuals who are promiscuous, have multiple affairs, or participate in novel sexual expressions, not all are sexually addicted (Rosenberg et al., 2014). Sexual addiction as a disorder may be present when an individual demonstrates "compulsive sexual behavior that results in tolerance, escalation, withdrawal, and a loss of volitional control despite negative consequences" (Riemersma & Sytsma, 2013, p. 308) and when this behavior begins to dominate the individual's life.

Two Types of Sexual Addiction

Classic sexual addiction. Researchers and clinicians have believed for decades that sexual addiction is attachment-related, and many consider it to be an intimacy disorder (Schwartz & Southern, 2017). This is the basis of the “classic” form of sexual addiction, which results from histories of abuse or trauma, insecure attachment within the family of origin, and/or poor impulse control (Giordano, Cashwell, Lankford, King, & Henson, 2017; Riemersma & Sytsma, 2013). Classic sexual addiction typically has a gradual onset, is accompanied by cross-addictions, and is believed to function as a self-soothing coping mechanism for comorbid mood disorders such as depression and anxiety (Riemersma & Sytsma, 2013; Giordano et al., 2017).

Philaretou (2006) asserts that sexual addiction is not just about an individual’s pursuit of sexual satisfaction and attainment of sexual satiation but involves sex as a way to camouflage ongoing efforts to try to meet one’s own emotional and psychological needs. Goodman (1993) states that sexual behaviors become the primary coping mechanism for individuals with sexual addiction. For sex addicts who experienced childhood trauma, the addiction is generally not a strategy for pleasure seeking, but a strategy for survival (Fisher, 2007). In this view, sexual addiction is more about attachment, intimacy, and connecting with self and other than about sex per se (Schwartz & Southern, 2017). The sexual behaviors continue due to both negative and positive reinforcement, and the compulsive sexual behaviors affect the brain’s reward circuitry similarly to drugs of abuse (Giordano et al., 2017).

Bowlby (1982) defined attachment behavior as “any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world” (p. 668). Attachment behaviors begin in infancy and continue throughout the life span. Bowlby suggested that an individual’s attachment

behavior is best recognized during an emergency or in a distressing situation. These lifelong attachment behaviors are informed by the individual's internal working model, which encompasses mental representations of the individual's self as well as attachment figures (Bowlby, 1982). When individuals experience abuse, abandonment, and/or neglect, their basic needs are unmet, relational skills are dysfunctional, fear of intimacy develops, and communication and conflict resolution skills are either inappropriate or underdeveloped (Riemersma & Sytsma, 2013). Additionally, chronic violations of boundaries, rigid roles, and family history of addiction further impair development and may produce shame, isolation, loneliness, anxiety, anger, and/or an intense sense of worthlessness (Riemersma & Sytsma, 2013).

Considering behaviorism's core theoretical proposition (operant conditioning), the problematic and pathological behavior of sexual addiction is maintained through positive reinforcement when sex addicts learn that their sexual desires can be satisfied by viewing sexually explicit material online or engaging in cybersex using the Internet (Griffiths, 2012). Further, these behaviors are negatively reinforced when users are able to escape the problems and pressures of everyday life by spending time online. Online sex thereby becomes a coping skill to relieve stress, occurring on a variable-ratio schedule that is effective in maintaining the participation in the sexual behavior (Griffiths, 2012).

Additionally, classical conditioning increases the likelihood of problematic online sexual behavior by pairing the use of online sexual behaviors with physical arousal. As the two become associated, conditioning elicits physical arousal (the conditioned response) merely by using the technology (the conditioned stimulus). The result is that just seeing a computer screen, hearing a router connect to the Internet, or feeling the physical sensation of typing on a keyboard can all

serve as triggers that elicit sexual arousal without consuming sexually explicit material online, causing sex addicts to pursue online sexual activities again (Carnes, 2003). Traditional behaviorism can explain why individuals continue to engage in online sexual behaviors despite numerous negative consequences (Barak, Fisher, Belfry, & Lashambe, 1999; Griffiths, 2012).

Abuse stories are shockingly prevalent among “classic” sex addicts, and Carnes’ (1991) research with over 1,000 sex addicts revealed that 97% experienced emotional abuse, 72% were physically abused, and 81% were sexually abused. Other studies have produced comparable results, and a strong predictive correlation has been noted between a history of childhood abuse and later development of sexual addiction (Opitz, Tsytarev, & Froh, 2009). Early traumas of emotional, physical, and sexual abuse have been shown to drastically influence neurodevelopment, which has been linked to sexual behavior problems (Creeden, 2004; Katehakis, 2009).

A study of 2,450 men and women in Sweden found that an estimated 12.1% (n=1,279) of hypersexual men and 6.8% (n=1,171) of hypersexual women had experienced separation from their parents during childhood (Langstrom & Hanson, 2006). A hallmark risk factor for sexual addiction is dysfunctional childhood attachment, which negatively impacts the individual’s affective, cognitive, and behavioral development, thus supporting the development and maintenance of sexual addiction (Coleman-Kennedy & Pendley, 2002; Karila et al., 2014; Katehakis, 2009; Langstrom & Hanson, 2006). Katehakis (2009) suggests that trauma dulls the right hemisphere of the brain that controls insight, emotional regulation, and the capacity to connect with others interpersonally, all of which are impaired qualities that characterize “classic” sexual addicts.

Contemporary sexual addiction. A second distinctive form of sexual addiction has emerged due to the tremendously rapid growth in Internet accessibility, which provides immediate access to sexually explicit material (Giordano et al., 2017; Riemersma & Sytsma, 2013). This second type of sexual addiction, referred to as “contemporary” sexual addiction, is not associated with abuse, trauma, or early attachment problems. Instead, its hallmark is “rapid-onset” features brought about by the toxic “3Cs”— chronicity, content, and culture (Riemersma & Sytsma, 2013). In this form of sexual addiction, recurrent, frequent, and prolonged exposure to sexually graphic content disrupts normal neurochemical, emotional, sexual, and social development, especially when it occurs during the early developmental process (Giordano et al., 2017). This exposure to sexually explicit material is reinforced by an exceedingly sexualized culture, which creates the “perfect storm” through which sexually addictive behaviors can emerge (Riemersma & Sytsma, 2013). The chronicity and content, paired with fast-changing cultural sexual norms, quickly trend toward virtual and nonrelational sex. Recently, sexual addiction has become prevalent among individuals who appear not to have experienced attachment-related problems (Giordano et al., 2017).

A unique feature of “contemporary” sexual addiction is that wherever technology is accessible, it appears to have an equal effect on all ages, genders, cultures, races, educational levels, and socioeconomic classes (Riemersma & Sytsma, 2013). The impact of “contemporary” sexual addiction on youth is of particular concern for the age group Riemersma and Sytsma (2013) refer to as the “GenText” generation (approximately 26 years and younger). This age group’s neurological, social, emotional, and sexual development has been dramatically shaped due to early and chronic exposure to the Web’s sexually explicit content; this may have created trauma depending on the age of first exposure. Such trauma can impair the development of

executive functioning and impulse regulation in the prefrontal cortex, which can lead to social isolation stemming from excessive online consumption that prevents normal relational development (Riemersma & Sytsma, 2013). Memories of emotionally aroused experiences get “locked into the brain” by epinephrine, an adrenal gland hormone, and are very difficult to erase, which could explain the addicting effect of pornography (Panjab, 2014).

Internet pornography use has been strongly correlated with social isolation, loneliness, depression, and impaired interpersonal/sexual relationships (Riemersma & Sytsma, 2013). The “Triple-A Engine” of online pornography addiction includes the factors of *accessibility* (i.e., myriad sites are available seven days a week, 24 hours a day), *affordability* (i.e., competition keeps prices low and many “free” sex sites exist), and *anonymity* (i.e., users perceive that their communications are anonymous) (Cooper et al., 2000). The cyclical pattern of cognitive and physiological stimulation evoking loneliness and isolation is enabled by the Triple-A Engine.

Diagnostic Criteria

Psychiatry has repeatedly tried to formulate diagnostic criteria related to sexual addiction, yet there is still no official diagnosis. In 1998, psychiatrist Ariel Goodman recommended criteria for sexual addiction based on the diagnostic criteria for substance use disorders. His diagnosis involved three or more of the following criteria displayed in the same a 12-month period: (a) tolerance; (b) withdrawal; (c) sexual behavior engaged in over a longer period of time than intended; (d) unsuccessful attempts to cut down/control behavior; (e) a great deal of time spent in preparation for the behavior; (f) interference with social, occupational, or recreational activities; and (g) sexual behavior continues despite psychological or physical problems caused by the behavior (Rosenberg et al., 2014). Later, Carnes (1991, 2005) recommended 10 diagnostic

criteria for sexual addiction similar to those proposed by Goodman and based on data from more than 1,600 clinical cases.

In 2010 and 2011, workgroups for the *DSM-5* considered two diagnoses related to sex addiction: hypersexual disorder, a nonparaphilic sexual behavior disorder, and Internet addictive disorder (Rosenberg et al., 2014). Kafka (2010), a member of the Sexual and Gender Identity Disorder Work Group, recommended that the diagnosis of hypersexual disorder be included in the *DSM-5* (APA, 2013), but his diagnostic criteria did not include dependence, tolerance, and withdrawal. It did, however, include other key features of addiction. The characteristics that distinguish this diagnosis involve “the presence of repetitive and intense preoccupations with sexual fantasies, urges, and behaviors, leading to adverse consequences and clinically significant distress or impairment in social, occupational, or other major areas of functioning” (Fong et al., 2012, p. 280). A wide range of sexual behavior can occur with hypersexuality, including cybersex addiction, which involves excessive use of Internet pornography, paid online sex, and chat rooms (Rosenberg et al., 2014).

Prevalence of Sexual Addiction

According to Cooper, Delmonico, and Burg (2000), at the beginning of 1998, approximately nine to 15 million people accessed the Internet daily, a rate that was increasing by 25% every quarter. By the mid-1990s, approximately 9 million people in the U.S. alone had accessed at least one of the top five “adult” websites. Juniper Research (2013), a specialized company in market and business research, estimated that by 2017, a quarter of a billion people would be accessing adult content online, including videos, images, and live cams, through personal mobile devices—more than a 30% increase from 2013. Additionally, mobile adult videochat is expected to experience a growth rate of 25% annually from 2013 to 2017, an

increase attributable to its emphasis on high-definition, niche-centric products and the availability of free content (Juniper Research, 2013).

Researchers estimate that 3% to 6% of the U.S. general population may suffer from hypersexuality, or sexual addiction, of whom 80% or more are male (Bradley et al., 2016; Fong et al., 2012; Karila et al., 2014; Kor et al., 2013; Kraus et al., 2016; Paul, 2009; Piquet-Pessoa & Ferreira, 2014; Seegers, 2003). However, Ferree (2002) argued that women with sexual addiction have been underreported, estimating that 40% to 50% of sex addicts are women. The average age range of males suffering from hypersexuality is between 27 and 36 years, with the average age of onset at 18 years; for females with sexual addiction, the mean age is 33 years (Ahmad et al., 2015). Men are more likely to seek professional help than women (Karila et al., 2014; Kraus et al., 2016; Paul, 2009).

Research suggests that men and women get involved in different forms of online sexual behaviors. Overall, men prefer to seek out sexual arousal based on visual sexual images that are used as masturbatory aids, while women typically seek out chat rooms that provide erotic narratives and/or a sex partner and are less likely than men to masturbate to online sexual materials (Corley & Hook, 2012; Paul, 2009; Schneider, 2000). In Schneider's (2000) study of 55 cybersex users (n=45 men; n=10 women), 92% of the men and 90% of the women stated that they considered themselves sex addicts.

Types of Internet Users for Sexual Pursuits

Individuals with an Internet connection can access the Internet any time, day or night, for free or at little cost; assume any identity they choose; and engage in behavior that is hidden or done secretly. Three types of online users use the Internet for sexual pursuits (Cooper, Putnam, Planchon, & Boies, 1999). The first type, *recreational users* (nonpathological), access online

sexual material out of curiosity or for entertainment, in ways that are not typically considered to be problematic (Cooper et al., 2000). Recreational users may eventually become indifferent to or bored with the online sexual activities or may require emotional involvement in a face-to-face interaction to prolong their sexual interests.

The second type, *sexual compulsive users*, demonstrate sexually compulsive traits that are problematic and engage in unconventional sexual practices that involve pornography use, multiple affairs/sexual partners, phone sex, and/or use of prostitutes (Cooper et al., 1999; Derbyshire & Grant, 2015; Kraus, Voon, & Potenza, 2016; Rimington & Gast, 2007; Wéry & Billieux, 2017). It is important that unconventional sexual practices be considered, interpreted, and applied in a cultural context. Schneider (2000) found that sexually compulsive users spent at least 11 hours per week engaged in online cybersex activities.

The third type, *at-risk users*, have no history of sexual compulsivity yet experience problems due to their online sexual pursuits (Cooper et al., 1999, 2000). These users may have vulnerabilities or propensities for sexual compulsivity, but they possessed sufficient impulse control mechanisms to resist acting on these behaviors until they gained access to the power of the Triple-A Engine: accessibility, affordability, and anonymity (Cooper et al., 1999). This power, interacting with underlying personality factors, can lead to behaviors and patterns that may develop into online sexually compulsive behaviors (Cooper et al., 2000; Griffiths, 2012; Schiebener, Laier, & Brand, 2015; Wéry & Billieux, 2017).

Evidence-Based Treatments for Sexual Addiction

Pharmacological Interventions

Some medications have been found to be effective in treating sexual addiction when used in conjunction with psychotherapy. These include SSRIs, anti-anxiety agents, antidepressants,

opioid antagonists, mood stabilizers, antipsychotics, and anti-androgen and surgical interventions. These medications are aimed at diminishing dysfunctional sexual behaviors, reducing cravings, improving desired sexual experience outcomes, and treating comorbid psychiatric disorders (Acharjee et al., 2014; Derbyshire & Grant, 2015; Fong et al., 2012; Garcia & Thibaut, 2010; Rosenberg et al., 2014).

Psychotherapeutic Interventions

To date, no significant placebo-controlled, double-blind studies have been conducted on any psychotherapeutic or biological treatments for sexual addiction (Garcia & Thibaut, 2010; Rosenberg et al., 2014). The best approaches for the treatment of sexual addiction are based on case reports and uncontrolled studies. The best-known psychological treatments, which are described thoroughly in the next section, include CBT (Acharjee et al., 2014; Derbyshire & Grant, 2015; Fong et al., 2012; Garcia & Thibaut, 2010; Rosenberg et al., 2014), BPT (Acharjee et al., 2014; Derbyshire & Grant, 2015; Garcia & Thibaut, 2010; Rosenberg et al., 2014), MI (Acharjee et al., 2014; Rosenberg et al., 2014), GT/12-step groups (Derbyshire & Grant, 2015; Fong et al., 2012; Garcia & Thibaut, 2010; Rosenberg et al., 2014), and MBCT (Fong et al., 2012; Reid et al., 2014; Witkiewitz et al., 2014).

The Top Five Evidence-Based Treatments for Sexual Addiction

As noted above, findings on the best treatment approaches for sexual addiction are based on the results of uncontrolled studies and case reports, as no significant experimental studies have investigated psychotherapeutic or biological treatments for sexual addiction (Garcia & Thibaut, 2010; Rosenberg et al., 2014). The best-known psychological treatments are the empirically-supported interventions discussed below.

Cognitive Behavioral Therapy

The most recommended treatment for sexual addiction is CBT (Fong et al., 2012; Garcia & Thibaut, 2010), an individual therapeutic approach that combines principles from cognitive and behavioral therapy (Cully & Teten, 2008). CBT focuses on examining patterns of thinking in which an individual's incorrect beliefs drive thoughts that result in self-destructive behaviors (Young, 2009). Sex addicts are taught to identify and monitor the thoughts that trigger sexually addictive feelings and actions, rewrite their cognitive distortions about sexual behaviors, and learn new coping skills that will prevent future relapse (Young, 2009).

The core theoretical proposition of CBT is that one's feelings and behaviors are caused by one's thoughts, rather than by external events such as people and situations. CBT contends that individuals learn most emotional and behavioral reactions, so they must unlearn emotional and behavioral reactions that are unwanted. A basic assumption underlying CBT is that disturbances in cognitive processes result in psychological distress, and changing these cognitive processes brings about positive changes in behavior and affect (Cully & Teten, 2008). CBT teaches clients to recognize the distortions within their thought processes that cause psychological pain by comparing these distorted thoughts to reality and other assumptions. Clients learn to develop coping skills that improve cognitive awareness, which helps correct the behavioral patterns that reinforce the cognitive distortions (Mulhauser, 2008).

CBT focuses on learning and practicing various coping skills that help individuals reduce/eliminate sexual addiction (Center for Substance Abuse, 1999). The therapeutic goals of CBT involve three core elements: functional analysis, coping skills training, and relapse prevention (Rotgers, 1996). CBT works by helping clients develop skills that make them conscious of their thoughts and emotions; help them identify how situations, thoughts, and

behaviors influence their emotions; and change those thoughts and behaviors to improve their emotions (Cully & Teten, 2008). Clients learn to recognize the situations in which they are most likely to engage in unwanted sexual behavior, learn ways to avoid those situations and implement coping skills that will help them deal more effectively with the situations, feelings, and behaviors associated with the sexual addiction (Carroll, 1998).

In *A Therapist's Guide to Brief Cognitive Behavioral Therapy* (Cully & Teten, 2008), the differences are explained between traditional CBT, which usually involves 12 to 20 sessions, and brief CBT that reduces the number of sessions to four to eight. This brief CBT manual explains that therapy begins with case conceptualization, in which the therapist builds rapport with the client and establishes a relationship using empathy, genuineness, positive regard, and active listening. The therapist orients the individual to CBT, provides psychoeducation about the structure and expectations of therapy, and assesses the client's needs (Cully & Teten, 2008). The therapist completes a thorough functional analysis of the client's sexual behaviors, attempting to identify the antecedents and consequences that trigger and maintain the sexual addiction. The antecedents involve the emotional, cognitive, social, environmental (situational), and physiological domains (Center for Substance Abuse, 1999).

Once high-risk situations have been identified for the individual, the thoughts, feelings, and actions that occurred during and after these situations can be assessed to determine the individual's coping abilities and self-efficacy perceptions. This thorough assessment assists in determining specific individual interventions and effective treatment planning. During this collaborative process, the therapist and client set outcome goals that are observable, measurable, and achievable, and relate to the specific coping skills that will be addressed in treatment (Cully & Teten, 2008).

Case conceptualization may continue into the second session, at which time the therapist also begins intervention techniques that deal with maladaptive thoughts, promote positive behavioral activities, provide problem-solving strategies, and support relaxation; the Dysfunction Thought Record may be used to help change maladaptive thoughts (Cully & Teten, 2008). Using a three-column chart to identify and rate situations and the thoughts and emotions that accompany them, the Dysfunction Thought Record enables the client to identify alternative thoughts that lead to balanced thinking.

As cognitive processes and moods change, other techniques are implemented to increase positive activities, or *behavioral activations*. In continuing sessions, the therapist helps the client develop and implement coping skills to effectively deal with high-risk situations, as well as behavioral skills for initiating and maintaining interpersonal relationships (Center for Substance Abuse, 1999). Such skill development is a major component of CBT and may involve the therapist modeling an effective coping skill, then encouraging the client to participate in a role-play to rehearse the new coping behavior. Between sessions, the therapist assigns homework that gives the client opportunities to try out the coping behavior in real-life settings, then to discuss these efforts in the next session.

As changes in thought processes and behaviors occur, the third component of CBT, relapse prevention, is implemented. Many individuals fear that they cannot manage future stressors without the help of the therapist (Cully & Teten, 2008). Relapse prevention involves heavily using functional analyses, identifying high-risk sexual situations, reinforcing the effective use of coping skills, and helping the individual develop a positive self-efficacy (Center for Substance Abuse, 1999).

At or near the end of treatment, the therapist reviews the coping skills the individual has learned and discusses which skills should be used in response to specific stressors or symptoms (Cully & Teten, 2008). This is also a time to consider, identify, and prepare for difficult situations, which empowers and encourages individuals to make proper plans for success. The behavioral part of therapy focuses on decreasing excessive sexual activity and thereby improving self-esteem, reducing elevated levels of depression and/or anxiety, and encouraging abstinence from any type of sexual behavior during the beginning of treatment (Garcia & Thibaut, 2010). Relapse prevention strategies are generally included as a part of this therapy.

Religiously integrated CBT (RCBT) follows the CBT principles described above, but the client's personal religious beliefs are explicitly used as a major foundation to identify and replace unhealthy cognitive processes and behaviors, thus reducing and/or eliminating the sexually addictive behaviors (Pearce et al., 2015). As the client discusses events, triggers, symptoms, and reactions to the symptoms, the therapist frames this information within the traditional CBT model, but also listens with a "third ear" in order to frame the client's words in the context of the religiously integrative CBT model. The religious client's worldviews and value systems are generally based on sacred scriptures, which help the client shape more accurate and adaptive thinking. In every session, the client is taught to memorize scriptures and to apply the positive teachings found in scripture to correct and replace negative and erroneous thoughts.

Brief Psychodynamic Therapy

Brief psychodynamic therapy (BPT), which is derived from the four major schools of psychoanalytic theory (Freudian Psychology, Ego Psychology, Object Relations, and Self Psychology), looks at childhood experiences that have been internalized throughout life (Center for Substance Abuse, 1999). The word *psychodynamic* refers to "the forces of the mind that are

in motion” (Cabaniss et al., 2011, p. 4). When Freud coined the term, he was aware that the mind was ever-changing and that unconscious elements could at any time enter consciousness, and vice versa (Mitchell & Black, 1995). The psychodynamic approach seeks to understand that which is below the surface and motivates thoughts and feelings. Freud explained that the goal of psychodynamic therapy was “making conscious what has so far been unconscious” (Cabaniss et al., 2011, p. 5).

There are two levels of awareness that explain the impact of these conflicts and problems: the *conscious* level that involves experiences of which one is presently aware, and the *unconscious* level that comprises experiences that one cannot voluntarily access but are nevertheless the primary determinants of psychic life (Cabaniss et al., 2011; Jones & Butman, 2011). The conflicts and problems experienced during the early years of life are stored at the unconscious level where a person does not consciously dwell on them, but they can be the driving force underlying individuals’ thoughts, feelings, perceptions, and reactions throughout life (Cabaniss et al., 2011). The memories of these experiences may be inaccurate, but they form the basis of the clients’ thoughts, feelings, perceptions, interpretations of past events, and behaviors as well as how clients relate to others (Cabaniss et al., 2011).

The mind can be divided into three basic functions: (a) the *id*, or the unconscious sexual and aggressive energies; (b) the *ego*, which manages the id and maintains balance between the id and external reality; and (c) the *superego*, which forms between age 5 and puberty and attempts to control the drives of the id by using guilt (Center for Substance Abuse, 1999). Anxiety can result from the unconscious conflict occurring between these three ego states (Cabaniss et al., 2011; Jones & Butman, 2011). The ego attempts to control anxiety in direct and rational ways, but often defense mechanisms are implemented to protect the ego from becoming overwhelmed

by anxiety (Center for Substance Abuse, 1999). These mechanisms operate unconsciously and “deny, distort, or falsify reality” (Center for Substance Abuse, 1999, p. 131).

BPT, a shortened version of psychodynamic therapy, focuses on the deeper causes of sexual addiction (Acharjee et al., 2014) by addressing the unconscious processes associated with past events that manifest in an individual’s current behavior (Center for Substance Abuse, 1999). Unlike psychoanalysis, which requires at least two years of therapy, brief psychodynamic therapy typically requires no more than 25 sessions, although it can involve as many as 40 sessions. Its goals include promoting self-awareness and understanding of how past events influence present behavior.

BPT emphasizes identifying a single central focus, rather than allowing the client to discuss unrelated topics at will (Center for Substance Abuse, 1999). The client and therapist agree upon this central focus during the first or second therapy session and it becomes the goal of therapy. The therapist is actively responsible for keeping the client on topic during the sessions.

Supportive-expressive (SE) psychotherapy is a form of BPT that was adapted for substance abuse disorders (Center for Substance Abuse, 1999) and can also be applied to sexual addiction. SE uses the phrase *core conflictual relationship theme* (CCRT) to describe the core problems individuals develop during childhood and to represent how individuals interpret others’ reactions to themselves, referred to as the *core response from others* (RO). The RO, in turn, results in a *core response of the self* (RS), capturing how individuals view themselves.

The CCRT and RO are unconscious processes, but from the perspective of SE, once individuals know what is occurring at the unconscious level and understand their childhood experiences, they will have better control over their behaviors. SE contends that individuals who suffer from addictions have negative expectations of others’ attitudes toward them. Many

individuals with sexual addiction use sexual behaviors to self-medicate in response to feelings of low self-esteem and low self-worth, which are reflected in the individual's RS (Center for Substance Abuse, 1999). The RO reinforces a negative RS, leading to the deceptive and manipulative behaviors often seen in this population.

In the therapeutic process, the first goal of therapy is to establish the therapeutic alliance, a relationship between therapist and client that is built upon honesty, empathy, trust from the therapist, and intimate self-disclosure from the client (Center for Substance Abuse, 1999). During this process the therapist must determine the client's level of developmental functioning, as sexual addiction represents the need for gratification in a low-level stage. As the therapeutic alliance builds and the client begins to understand and deal with conflicts at the unconscious level, the client can start to grow stronger and move forward developmentally, which helps the client gain insight, another important aspect of therapy.

Insight involves both thoughts and feelings and refers to a greater understanding of oneself, one's internal processes, and/or one's behavior that leads to change. As a result, the client may begin to deal with defense mechanisms, which are the ego's attempt to defend itself from the anxiety produced by the individual's experience with his/her environment (Center for Substance Abuse, 1999). Defense mechanisms may take the form of denial, displacement, grandiosity, identification, introjection, isolation, projection, reaction formation, regression, repression, or undoing.

Often dysfunctional sexual behaviors are mechanisms to deal with core conflicts involving shame, anger, avoidance, low self-esteem, and other negative core beliefs. In the context of therapy, as these conflicts arise, clients may use the therapeutic relationship as a site of transference, transferring key unresolved conflicts with others onto the therapist. As the

therapeutic relationship grows, transference can be used in therapy to help clients begin to understand the driving force behind their sexual addiction and to consider other, more positive behaviors in which to engage.

Motivational Interviewing

Motivational interviewing (MI) is a client-centered, directive intervention involving a collaborative effort between the therapist and client. It is designed to help individuals resolve ambivalence about changing negative behaviors and increase their intrinsic motivation to change those behaviors. Miller and Rollnick (2013) define MI as “a collaborative conversation style for strengthening a person’s own motivation and commitment to change” (p. 12); that is, MI is a motivational conversation about change. The primary purpose behind MI is to strengthen the individual’s own motivation for change, which is incomplete without the individual’s commitment to change.

Four key elements underlie the spirit of MI: *partnership* (an active collaboration done “for” and “with” a person), *acceptance* (the therapist’s unconditional positive regard, empathy, support for the client’s autonomy, and affirmation of the client’s strengths and weaknesses), *compassion* (the therapist’s promotion of the client’s welfare and needs), and *evocation* (the therapist’s eliciting of the individual’s existing thoughts about and arguments for change) (Miller & Rollnick, 2013). MI also encompasses four key processes, beginning with *engaging*, which involves establishing a working relationship that creates a connection between therapist and client. Because it establishes the therapeutic alliance, engaging is a prerequisite for the other three processes (Miller & Rollnick, 2013).

In the second process, *focusing*, the therapist develops the conversation to maintain a specific direction that centers on changing the sexual behaviors (Miller & Rollnick, 2013).

Evoking, the third process, lies at the heart of MI and involves eliciting the client's own motivation to change their sexual behaviors, within an environment of compassion and acceptance. The fourth process, *planning*, involves formulating a plan of action to change the sexual behaviors once the person is ready to commit to changing those behaviors (Miller & Rollnick, 2013).

The four MI processes utilize four core interviewing/communication skills that make up the acronym OARS (Miller & Rollnick, 2013). The therapist asks *open-ended questions* that prompt a discussion between the therapist and client and keep the communication flowing. During the discussion, the therapist *affirms* the client by reinforcing the client's strengths, positive steps, and intentions in the proper direction. During *reflective listening*, the therapist restates the thoughts and feelings the client has expressed, allowing clients to hear again what they have said but in different words that they can ponder. Through *summarizing*, the therapist validates the client by showing that the therapist has been listening, remembering, and valuing what the client has said. Summarizing also elicits the client's motivations, intentions, and actual plans for change. Information and/or advice can be helpful to the client but should only be given when the client asks for them, or with the client's permission (Miller & Rollnick, 2013).

MI works to help move the individual through the stages of addiction and change as outlined by DiClemente (2006). These include (a) the *precontemplation stage*, in which change is viewed as unwanted, unneeded, irrelevant, or impossible to accomplish; (b) the *contemplation stage*, which examines the problematic behavior and considers change on a risk–reward basis; (c) the *preparation stage*, in which the individual not only makes a commitment to change the behavior but also develops a plan or strategy for making the change; (d) the *action stage*, which involves implementing the plan to change the present negative behavior and start a new

behavioral pattern; and (e) the *maintenance stage*, which involves sustaining the new behavior for a prolonged period of time and integrating the behavior into the individual's lifestyle.

Overall, MI focuses on helping the client overcome ambivalence about changing sexual behaviors, reinforces the client's ideas regarding reasons to change those behaviors, and helps strengthen the client's commitment to changing sexually addictive behaviors (Miller & Rollnick, 2013). MI not only helps those with sexual addiction recognize the need for change, but also assists them in making changes that prevent relapse (Nathan & Gorman, 2007).

Group Therapy

Group therapy (GT) is a therapeutic approach involving a small number of individuals, called group members, and one or more group therapists who are specially trained for group work (Brabender et al., 2004). GT is powerful in that it produces positive effects in most cases. GT is designed to encourage group members to improve psychologically by exploring their cognitive and affective interactions within the group environment, both among and between group members and with the therapist(s). Garland (2010) explains that a "therapy group is a unit defined as separate from its wider social context. Group members only meet each other within the sessions. What is said within each session remains private to that session. Confidentiality is important" (p. 37). In this setting, group members can say things to each other that would not be said in normal, daily social situations.

Freud distinguished this type of group from just a collection of individuals by explaining that "the key element for a group is the presence of a leader with whom members could identify and with whom they could form an attachment" (Brabender et al., 2004, p. 5). Because of their common relationship with the group leader/therapist, group members are able to identify with one another, allowing empathy to develop; this also enables members to share in each other's

psychological lives. Further, members must first deal with their own feelings and impulses toward the leader before attempting to struggle with their relationships with other members.

Each group has an identified purpose and function that it aims to fulfill. Individuals selected to participate in the group must be suitable candidates for group therapy, based on criteria identified in the *APA Code of Ethics* (2005): “To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience” (p. 5). It is the group leader’s responsibility to determine the group composition with regard to size, gender, type of client, and whether the group will be open or closed (DeLucia-Waack, Gerrity, Kalodner & Riva, 2004).

Little guidance exists in the research literature concerning the best methods of identifying potential clients and determining the type of group format (DeLucia-Waack et al., 2004). However, DeLucia-Waack et al. (2004) note that group leaders generally agree that key criteria include each client’s interpersonal and intrapersonal characteristics, social ability, frustration tolerance, expectations regarding the benefits of group therapy, and commitment to changing interpersonal behaviors. Pre-group preparation has been shown to be important in promoting the development of group cohesion by reducing anxiety, increasing therapeutic participation and adjustment, and enhancing the overall group experience (Hannah, 2000).

The group leader/therapist plays a critical role in establishing a positive environment for the group members. Group leaders must express warmth, empathy, and genuine concern for group members (DeLucia-Waack et al., 2004), establishing a supportive relationship with each member that fosters client change. Group leaders must be psychologically healthy, confident in their leadership ability, and comfortable in a position of authority (Jacobs, Masson, Harvill &

Schimmel, 2012). Group leaders are encouraged to actively pursue personal growth outside the group, to avoid allowing unresolved personal problems to surface during group therapy.

Leaders must use caution regarding self-disclosure, ensuring that it involves only disclosures that are in the best interests of the group members and not in the best interest of the leader (Edwards & Murdock, 1994). Self-disclosure is justified when it is used to model appropriate behaviors for the group members. A successful group leader must have experience in individual and group counseling, knowledge of the topic, strong planning and organizational skills, a good understanding of counseling theories, and preparation for dealing with human dilemmas and conflicts (Jacobs et al., 2012). Group leaders must also be knowledgeable about ethical issues and be skilled in assessment and evaluation (Hensley, 2002).

Of all the decisions a group leader must make, the decision regarding which theoretical orientation to choose is one of the most important (Brabender et al., 2004). The theoretical orientation determines what is and is not a psychological problem and provides the conceptual framework through which the leader understands the meaning of what occurs in the group. The theory directs the leader's actions and interventions and guides the members in reaching their goals.

Once a group has been formed and establishes its goal, a structure must be developed to promote effective functioning (Garland, 2010). In the *beginning* stage of group therapy, the norms, goals, and supervision are established by defining (a) the group's purpose, function, and composition; (b) the group's meeting location; (c) the time meetings will begin; (d) the length of time the group will continue meeting to accomplish its purpose; (e) group norms for attendance, participation, and communication; (f) the rules for and limits of confidentiality; and (g) individual goals (DeLucia-Waack et al., 2004; Garland, 2010). The group's success will be

dependent on the leader's consistent application and reinforcement of the structure, which creates a safe, nonjudgmental environment; promotes cohesion, self-disclosure, and risk-taking among group members; and encourages members to model the leader's responsible behavior, dependability, and reliability.

The number of developmental stages involved in group formation can vary from three to seven. In the context of significant conflict or resistance among the members a *storming* stage can develop, but a creative and involved leader can prevent this stage from occurring (Jacobs et al., 2012). When a storming stage does occur, it is characterized by highly charged emotional issues, and the leader's main task is to help the group members move through this phase. The leader may struggle to understand the group members and their role in the process, and group members may challenge the leader's authority. The leader's response to such a challenge should be to avoid becoming defensive, instead responding openly to the group members (Brabender et al., 2004). By bringing up issues from the previous group meeting, the leader can help members move from session to session and advance to the next stage.

In the *working* stage, group members focus on the group's purpose; benefit from the participation of each member; and develop into a cohesive, balanced, trusting, and cooperative collective whose members are comfortable with self-disclosure (Jacobs et al., 2012; Yalom & Leszcz, 2005). The *closing/ending* stage is reached when the group's purpose is accomplished, and each group member's needs have been met. In a case where a group member continues to struggle at the end of the group, the leader should either refer the member to another group, recommend individual therapy, or both.

With regard to sexual addiction, group therapy offers individuals an opportunity to establish relationships that will assist them in managing sexually addictive behaviors, examining

the dynamics of the addictive process, and developing close bonds with others dealing with similar problems (Hook, Hook, & Hines, 2008; Rosenberg et al., 2014). Participation in these groups is generally recommended to provide support, fellowship, structure, and accountability (Acharjee et al., 2014).

Mindfulness-Based Cognitive Therapy

Mindfulness-based cognitive therapy (MBCT) practices have been found useful in treating addiction, including behavioral addiction, and may have potential benefits for sexual addiction (Witkiewitz et al., 2014). MBCT seems to weaken problematic characteristics in various psychiatric disorders that involve deficits in self-control (Frieze, Messner, & Schaffner, 2012), impulsivity (Peters, Erisman, Upton, Baer, & Roemer, 2011; Lattimore, Fisher, & Malinowski, 2011), and emotional regulation (Goodall, Trejnowska, & Darling, 2012). Impulsive behavior, emotional dysregulation, and difficulties with stress are common factors in sexual addiction (Kafta, 2010; Reid, Stein, & Carpenter, 2011).

Mindfulness can be defined as “the process of bringing awareness and acceptance to one’s moment-to-moment experience of thought, emotions, and bodily sensations in a nonjudgmental manner” (Bishop et al., 2004; Kabat-Zinn, 1990). In other words, mindfulness refers to maintaining a nonjudgmental awareness and acceptance of experiences in the present moment (Baer & Krietemeyer, 2006; Piet, Hougaard, Morten, Hecksher, & Rosenberg, 2010). Various meditation techniques have been incorporated into mindfulness, beginning with Buddhist traditions and practices, but contemporary psychology applies the clinical aspects of mindfulness and embraces it as a secular practice, outside a religious context (Baer, 2003; Witkiewitz et al., 2014).

MBT is similar to CBT in that it involves examining cognitive processes as they relate to triggers, urges, and cravings; reframes problematic experiences to become expected and tolerable (Bowen & Marlatt, 2009); and focuses on the client's "awareness of the process and nature of the thought, rather than on challenging its content" (Witkiewitz et al., 2014). As in cognitive restructuring and reframing techniques, clients learn to examine, observe, and reframe sexual-related thoughts, learn new coping skills to change sexual behaviors, and maintain new positive behavioral responses.

Mindfulness-based relapse prevention (MBRP) (Bowen, Chawla, & Marlatt, 2010; Witkiewitz, Marlatt, & Walker, 2005) is an 8-week manualized outpatient program that incorporates CBT skills and mindfulness-based practices to reduce the likelihood of relapse. MBRP practices and exercises are designed to increase awareness of and improve responses to triggers that generate sexual behaviors, helping clients transition from "autopilot" to paying attention to emotional, physical, and cognitive experiences, whether triggering situations or routine daily activities.

The first and second sessions of MBRP introduce the concept of mindfulness and explain its relevance to relapse prevention, focusing on increasing individuals' awareness of external triggers and patterns of emotional, cognitive, and behavioral reactions. Clients are taught to recognize urges to impulsively react; practice alternative strategies of remaining with their discomfort; pause before reacting; and choose better, more skillful responses. Clients are given coping exercises for triggering stimuli and provided with several options for practicing skills between sessions, such as listening to recordings of mindfulness instructions and completing worksheets that focus on individual patterns of cognitive, emotional, and behavioral reactivity and their antecedents.

In the third and fourth sessions, clients practice exercises that help them explore and identify underlying needs that result in reactions to urges and learn multiple strategies that provide alternatives to current impulsive behavioral choices. For example, in Session Three the therapist introduces the “Stop Observe Breathe Expand Respond (SOBER) Breathing Space” exercise (i.e., Stop or slow down; Observe what is happening; Bring attention to Breathing; Expand awareness to the whole body; Respond mindfully, with awareness) (Witkiewitz et al., 2014). This short, simple practice can be used in each session.

Session Five centers on balance and the interrelationship between accepting what is taking place and making real changes through skillful actions (Witkiewitz et al., 2014). In Session Six, the therapist emphasizes thought content and its relationship to the relapse cycle. Exercises are designed to increase awareness of thoughts and how they are experienced, and to help clients recognize that thoughts are just thoughts and are not always the truth. The last two sessions focus on applying the new practical skills in daily life, strengthening social support networks, and establishing contact with support resources. Forgiveness and self-compassion exercises are also practiced, offering alternatives to aggressive or harmful behaviors.

Throughout these sessions, clients learn cognitive-behaviorally-based exercises along with mindfulness practices, developing a greater awareness of the sequence of reactions that follow a trigger and can lead to relapse (Witkiewitz et al., 2014). As clients come to recognize this succession of events, they learn to pause before engaging in the reactive behavior, regardless of the situation. As they learn to identify the underlying craving/urge, moreover, they can meet the need more skillfully and effectively. The content and practices of MBRP are non-judgmental, compassionate, and encouraging, and are carried out with kindness to reduce shame, self-blaming, and self-defeating behaviors (Marlatt & Gordon, 1985).

The Church, Pornography Use, and Sexual Addiction

When pornography use and sexual addiction are examined in the context of religiosity, they become even more complex issues (Grubbs et al., 2010). Generally, religions teach that sexual desires and behaviors are morally appropriate only in monogamous, married, heterosexual relationships; the texts of all three Abrahamic faiths contain explicit commands to avoid lustfully looking at others (Perry, 2016; Reid et al., 2016; Whitehead & Perry, 2017). Religious teachings have had a significant role in establishing sexual attitudes in societies overall (Reid et al., 2016), and generally, religious beliefs are associated with negative and restrictive attitudes toward sexuality, especially Internet pornography (IP) use (Ahrold, Farmer, Trapnell, & Meston, 2011; Bradley et al., 2016; Grubbs & Hook, 2016).

In the United States alone, numerous studies have documented that highly religious Christians disapprove of pornography use (Bradley et al., 2016; Lambe, 2004; Lottes, Weinberg, & Weller, 1993; Thomas, 2016). Yet despite these views and their own moral uneasiness, many religious individuals admit to using IP (Bradley et al., 2016; Nelson et al., 2010). Although there is growing cultural acceptance of pornography use in the U.S., religious groups continue to strongly discourage using pornography or other sexually explicit materials to arouse sexual desires outside the bounds of marriage or encourage solo masturbation (Perry & Hayward, 2017). Thus, this creates an important challenge in emerging adulthood, as individuals attempt to integrate sexual desires and feelings with religious/spiritual values. *Sexual congruence*, defined as the degree to which individuals' sexual values and behaviors align, is an important predictor of sexual and spiritual well-being (Bradley et al., 2016; Griffin et al., 2016; Hook et al., 2015; Yonker, Schnabelrauch, & DeHaan, 2012). The sanctification theory states that when sacred importance permeates individuals' sexual values and their sexual values and behaviors are

congruent, sexual expression is linked to positive outcomes (Pargament, Magyar, Benore, & Mahoney, 2005). However, when individuals' sexual values and behaviors are incongruent, and their behaviors violate the sacred values of self and community, *moral incongruence* occurs, resulting in a spiritual struggle and damage to their sexual self-concept (Exline, Pargament, Grubbs, & Yali, 2014; Hernandez, Mahoney, & Pargament, 2014; Perry & Whitehead, 2018).

Research suggests that persons with religious faith experience distress when their behavior and moral/religious beliefs do not align (Exline et al., 2014; Exline & Rose, 2014; Grubbs, Volk, et al., 2015). In light of religious institutions' strong opposition to pornography use, this population may be vulnerable to great distress regarding pornography viewing (Patterson & Price, 2012; Volk et al., 2016). Additionally, *cognitive dissonance* occurs in the minds of religious individuals if they believe pornography viewing is wrong but view it anyway (Nelson et al., 2010; Perry, 2017). Such a discrepancy between individuals' beliefs about what their behavior should be and their ability to live up to that standard can create tremendous guilt and shame (Hook et al., 2015; Kwee & Hoover, 2008). Thus, it is important to consider whether the source of distress is a discrepancy between religious beliefs and behaviors or the inability to refrain from sexually acting out (Reid et al., 2016).

Perceived Sexual Addiction

IP use is not always connected to negative consequences, and casual recreational use seems to be associated with more openness to experience as well as reduced sexual guilt (Grubbs, Volk, et al., 2015; Hald & Malamuth, 2008; Paul & Shim, 2008; Weinberg, Williams, Kleiner, & Irizarry, 2010). Yet when casual use increases and reaches the level of excessive or compulsive activity, negative consequences result (Grubbs, Volk, et al., 2015). It is often unclear whether religious persons, as well as those in the general population, suffer directly from

pathological IP consumption or if they suffer from “perceived addiction,” in which one perceives oneself as being addicted, although one’s actual pornography use is normal behavior and unproblematic (Grubbs, Volk, et al., 2015; Thomas, 2016).

Recent studies have found that religious individuals tend to view IP consumption as pathological, which explains the relationship between IP use and negative outcomes (Grubbs et al., 2015; Grubbs, Volk, et al., 2015). Religious individuals view IP negatively and their use of pornography results in decreased feelings of well-being. The belief that IP use is pathological suggests that the relationship between IP use and the associated negative outcomes goes beyond the use of IP per se (Wilt et al., 2016), and that other factors beyond using pornography may be driving the psychosocial problems related to IP use.

One study found that certain sexual practices were defined by many religious systems as permissible, while another study viewed the same practices as problematic (Grubbs, Exline, et al., 2015; Reid et al., 2016). Thus, moralistic beliefs can result in pathologizing sexual behaviors that would be otherwise classified as normal (Clarkson & Kopaczewski, 2013; Grubbs, Exline, et al., 2015). As a result, therapists who are highly religious are more likely to diagnose their clientele with sexual addiction than are their nonreligious colleagues (Hecker, Trepper, Wetchler, & Fontaine, 1995), although therapeutic training involves accurate and unbiased diagnostic procedures (Grubbs, Exline, et al., 2015). In religious populations, sexual expressions are often paired with shame and guilt, which can result in classifying as pathological those sexual behaviors that occur as part of normal development. Further, due to moral reactions, religious persons may consider a non-pathological behavior to be pathological, which could result in IP use being interpreted as addictive.

Recent research has examined the intersection of religion, spirituality, and sexual addiction and has connected religious beliefs to increased levels of self-perceived sexual addiction (Abell et al., 2006; Dhufar, Pontes, & Griffiths, 2015; Grubbs, Exline, et al., 2015; Grubbs & Hook, 2016). Bradley et al. (2016) found that among those who admit to using pornography, self-identifying as religious and having a certain belief in God were robust predictors of perceived addiction. It appears that often religious persons, specifically conservatively religious persons, will pathologize normal behavior in response to the shame and guilt of pornography use (Clarkson & Kopaczewski, 2013; Grubbs, Exline, et al., 2015; Grubbs et al., 2010; Dominguez, Ferrell, & Kwee, 2007; Ley, Prause, & Finn, 2014; Thomas, 2016). These individuals may experience “cognitive dissonance” and believe it causes pornography addiction; cognitive dissonance is the result of perceiving that pornography use is “physiologically” addictive and beyond volitional control (Clarkson & Kopaczewski, 2013; Thomas, 2016). Thomas (2016) proposes that conservative religious individuals are motivated to embrace a belief in pornography addiction because it allows them to relinquish moral responsibility for pornography use, alleviating shame and guilt.

Although IP has not been established as addictive, some individuals report *feeling* addicted to pornography, based on experiencing addictive patterns of consumption that interfere with their well-being and functioning (Bradley et al., 2016). Religiousness has been linked to increased depression and unhappiness among pornography users (Patterson & Price, 2012) and to an increase in perceived addiction to IP that is mediated by the moral disapproval of pornography use (Bradley et al., 2016; Grubbs, Exline, et al., 2015). Although there is no official diagnosis of IP addiction, researchers argue that non-compulsive IP activity can lead to compulsive and pathological use (Bradley et al., 2016).

Statistics for Sexual Addiction/Pornography Use in the Church

Recently, the Barna Group (2016), in partnership with Josh McDowell Ministry, conducted a landmark study entitled, *The Porn Phenomenon: The Explosive Growth of Pornography Use and How It's Impacting Your Church, Life, and Ministry*. The study examined the effects of pornography on pastors, churches, young people, and the general population. As reported in *Christianity Today* (Lee, 2016), approximately 3,771 individuals responded to the online surveys regarding pornography use, including 813 young people ages 13-24, 1,188 adults 25 years of age and above, and 1,770 pastors and youth pastors. The study reported that in the general population, 47% of men and 12% of women search for pornography at least one to two times per month. During the same period, approximately 27% of Christian men and 6% of Christian women actively search for pornography. In the general population, 54% of adults who actively view pornography daily say they view it “because it’s just fun” (Barna, 2016; Lee, 2016).

In the church context, the study found that 93% of pastors, 94% of youth pastors, and 75% of the laity believe pornography is becoming a greater problem, especially in the church. Yet only 7% of pastors reported that their church has a program in place designed to help people struggling with pornography use (Barna, 2016; Lee, 2016). Among the married and single Christian women who responded to the survey, 2% of married Christian women and 9% of single Christian women reported viewing pornography one to two times per month. In a 2010 survey conducted by *Today's Christian Woman Online* (Perkins, 2016), 34% of women readers said they intentionally searched for and accessed pornography. Perkins also reports that women are getting more and more involved in cybersex, and women are more likely than men to convert the

conversations online into real-life affairs; women are also increasingly accessing pornography while they are at work.

Among young adults ages 25-30, approximately 27%, or more than 1 in 4, reported viewing pornography for the first time before reaching puberty. In this same age group, 8% view pornography daily, 17% view it weekly, and 20% view pornography one to two times a month (Gordon, 2016). In the adult age group of 18–24, 12% report viewing pornography daily, 38% view it weekly (Lee, 2016), and 19% view it one to two times a month (Gordon, 2016). Also, in this age group, 32% reported that *most* of their friends view pornography regularly, while 17% reported that *all* of their friends view pornography regularly, and many view it daily (Barna, 2016). In the 13-17 age group, 8% reported viewing pornography daily, 26% reported viewing it weekly (Lee, 2016), and 17% reported viewing it one or two times a month (Gordon, 2016).

Among males who have contacted their pastor for help with pornography use, 59% are married men, 36% are unmarried men, and 33% are teenage boys. Pastors also report that 5% of married women, 5% of unmarried women, and 4% of teenage girls have sought help as a result of pornography use (Lee, 2016). Among teenage girls and young women, 33% reported that they searched for pornography at least once a month, and 12% of women ages 25 and up reported doing the same (Barna, 2016; Gordon, 2016; Lee, 2016).

Sixty-six percent of males and females under 24 years old reported that they had received a sexually explicit image (sexting) from someone they knew, and 44% reported sending a sexually explicit image to someone else (Gordon, 2016; Lee, 2016). These statistics suggest that the social stigma of viewing pornography is declining. Barna (2016) reported that when teens and young adults were asked to rank a list of morally objectionable actions, not recycling was

ranked as more objectionable than viewing pornography. However, practicing Christians are twice as likely as others to feel guilty about viewing pornography.

Females are the most overlooked population regarding sexual addiction because of misunderstandings about women and sex addiction (Ferree, 2001, 2003). Ferree identifies six myths about females and sexual addiction that have contributed to this oversight: (a) females are not sexually addicted; (b) females who might be addicted are relationship/love addicts rather than sex addicts; (c) females are motivated to act out because of neediness; (d) females' presenting problems can be taken at face value and given other diagnoses; (e) the consequences of addiction for females and males are the same; and (f) females should be asked the same diagnostic questions as men. According to Ferree (2001), women are more likely than men to remain silent about their sexual struggles due to shame and guilt.

Problems in Dealing with Sexual Addiction in the Church

With the increase of IP use, sexual problems, and sexual addiction within the religious community, the church needs to consider how it responds to sexual addiction, whether experienced by men, or women, or whether as addicts or co-addicts (i.e. individuals in a damaging relationship with an addict, unintentionally supporting the addiction). Individuals who seek help from the church have an elevated risk of receiving information that is incorrect and even harmful (Ferree, 2002). This results largely from misunderstandings about sexual compulsivity and confusion about terminology within the religious community. Ferree (2002) found that in the church, sexual "sin" may refer to a single behavioral occurrence that violates biblical teachings about sexual morality, yet through a lack of understanding sexual "sin" and sexual "addiction" automatically become associated. This is comparable to labeling anyone who

has ever consumed alcohol as an alcoholic. In this way, a spiritual matter turns into a clinical problem (Ferree, 2002; Volk et al., 2017).

When persons of faith are counseled, they may be instructed to seek sexual addiction treatment to deal with and overcome a sexual transgression, which is the type of problem with which the church is most prepared to help (Volk et al., 2017). This misunderstanding by church leaders may result in the unintended consequence of applying an addiction model to a non-pathological sin problem. Many faith communities continue to view addiction as a moral failure and strive to hold individuals personally responsible (Ferree, 2002; Nelson, 2003). Rather than recognizing addiction as a disease, the struggling “sinners” are viewed as needing repentance, not treatment. As a result, they may not receive accurate information or helpful tools for treatment, and they are rarely instructed to seek medical evaluations or take proper medications as needed. Further, the neurochemical, cognitive, and emotional aspects of sexual addiction are generally ignored by religious persons as they focus solely on the spiritual component (Ferree, 2002). There is little understanding within the church of the power of brain chemistry and its effects on sexual behavior, and neurobiological aspects may be entirely overlooked. Instead, those seeking help are advised to pray more and become involved in Bible study, both of which they have often been done previously, but without success (Ferree, 2002).

When a sexual problem is exposed, the church community typically extends little or no grace for the sex addict’s sin, and generally provides no treatment resources (Ferree, 2002; Lee, 2016). Most within the faith communities cannot comprehend compulsive sexual behaviors as simultaneously “sin” and “disease,” and because the church cannot be soft on sin, it takes a rigid approach. Ferree (2002) observes that 12-step programs for sexual addiction have been basically ignored as a main resource for church-based treatment mainly because these programs are

misunderstood and viewed as “New Age” heresy (p. 289). However, 12-step programs have strong spiritual tenets that emphasize “personal responsibility, repentance, and transformation” (Ferree, 2002, p. 289).

The religious community also incorrectly interprets sexual addiction as a reference to pedophilia and/or other offensive behaviors, escalating fear within the religious community (Ferree, 2002). Because of these incorrect assumptions and misunderstandings about sexual addiction, many religious persons, both male and female, are reluctant to seek help for themselves or for loved ones (Nelson, 2003). Within most religious circles, sexual sin is regarded as the worst transgression, which magnifies the shame of struggling with a sexually sinful disease (Ferree, 2002). The ultimate moral failure is admitting to out-of-control sexual behavior, and this is why most addicts remain silent. In view of the ridicule directed at high-profile leaders exposed for sexually compulsive behaviors, women and men of faith fear being treated similarly, as they are held to higher behavioral standards within the religious community than those in the secular community (Ferree, 2002). As a result, sexual addiction has thrived within the closed and rigid religious environment.

Individuals who attempt to seek help for sexual compulsivity are frequently advised to seek clergy-based counseling, yet they are often exposed to serious clinical mistakes by faith-based caregivers in two key areas: the distrust of secular approaches/treatments, and the lack of understanding regarding the nature of addiction (Ferree, 2002). The multi-faceted sexual addiction problem these individuals confront is viewed as a moral failure, and only a spiritual solution is used to address it. Some caregivers go so far as to consider it “unbiblical to explore family of origin problems in light of the commandment to ‘honor [thy] father and mother,’ and therefore Christian counselors may be reluctant to use a psychodynamic approach to address

addiction” (Ferree, 2002, p. 288). Many faith-based practitioners believe that the cure for trauma-based shame is involvement in religious service. This causes many men and women to feel betrayed and disappointed by the church’s lack of response to their problems (Ferree, 2002).

Church-Based Interventions

When the church attempts to help individuals who struggle with sexual addiction, church-based interventions may be inadequate because they potentially lack empirical support, a holistic perspective, and an individualized approach (Volk et al., 2017). When individuals turn to the church for help with sexual addiction, the church may treat all sufferers the same. Volk et al. (2017) suggest that when individuals present with sexual problems, particularly online pornography problems, the church’s first action should be to assess the severity of the problem. It is important to determine whether the individual is suffering from a sin problem or an addiction problem, as these problems should not be treated the same. If there are signs of addiction or another mental health disorder, or if church authorities are unsure about what to do, they should refer the individual to a trained, licensed professional who can properly assess the condition and provide treatment.

Research has found that individuals high in religiosity or conservative religious values more often perceive themselves as addicted to pornography, as compared to others, which results in feelings of shame and guilt (Abell, Steenbergh, & Boivin, 2006; Gilliland, South, Carpenter, & Hardy, 2011; Grubbs, Exline, et al., 2015; Thomas, 2016). Highly religious clients tend to self-identify as sex addicts because of the incongruence between their personal religious beliefs and their sexual behaviors, even when those behaviors do not meet the criteria for addiction (Giordano et al., 2017). Quite often in religious populations, sexual expressions are accompanied

by shame and guilt, and non-pathological behaviors are interpreted as pathological due to the moral reactions of the religious community (Grubbs, Exline, et al., 2015).

Shame refers to a negative evaluation of the entire self that leaves individuals feeling inadequate, experiencing painful self-disapproval, and believing that others view them as bad people (Adams & Robinson, 2001). *Guilt* is defined as a negative evaluation of the behavior and views it as bad, which is related to unresolved shame and guilt that was experienced during childhood and exaggerated in adulthood. When childhood trauma has been experienced by a sex addict, Fisher (2007) suggests that the addiction is more of a survival strategy as opposed to a pleasure-seeking behavior. Trauma impacts the limbic system and brainstem, which are emotional brain areas, as well as the amygdala that is responsible for the “fight and flight” response (Hall, 2011, p. 221). The amygdala may continue to be hypersensitive even after trauma has long passed, yet Fisher (2007) suggests that this hypersensitivity can be triggered by numerous external sources and result in hypo-arousal by the body’s sympathetic nervous system, or parasympathetic system that by-passes the thinking functions of the brain. Sexual behavior may numb various hyper-arousal feelings that result from trauma; thus, addiction may become behaviors that are self-medicating, and the addiction then becomes a source of shame that prolongs the addictive cycle (Hall, 2011). It is essential that individuals who seek help from the church receive not only spiritual help, but also help from a mental health professional who can assist the individual in resolving both spiritual and psychological pain. Ferree (2002) found that most people of faith must be challenged to consider receiving clinical help from within the secular community, yet the secular community has a greater understanding of sexual addiction and how to treat it.

To address the sexual addiction problem, “church leaders should actively seek information and research about identifying pathologies and effective programs for helping believers” (Volk et al., 2017, p. 3), which should include help for those individuals who experience sexually addictive as well as sexually problematic behaviors. A Google search on the Internet shows that the religious community offers faith-based curricula designed to treat sexual addiction, and some of these FBTs make their curricula available for use in the church. Some churches are making use of these curricula and are offering therapeutic treatments within the church, yet it is vital that these curricula be vetted to determine if they include the key EBT components that effectively treat sexual problems and sexual addiction.

Conclusion

Although behavioral addictions are controversial and, except for Gambling Disorder, are not listed as official diagnoses in the *DSM-5* (APA, 2013), research has established the negative effects of these disorders on the lives of those who experience them. Particularly, sexual addiction has become a major global problem and a mental health issue due to the rise of the Internet, which not only licensed professional counselors, but also the Christian church, must be prepared to address. For a variety of reasons, the Christian church has often avoided dealing with sexual addiction. Some churches and ministries are currently preparing to help individuals deal with sexual addictions and overcome their problematic sexual behaviors. It is unknown if these churches and ministries use curricula that include key EBT components shown effective in treating sexual addiction. It is also unknown if the FBT curricula differentiate between addictive and problematic sexual behaviors. Thus, the following chapter will present the research methods used in this study to determine if FBT curricula include key EBT components and if these FBTs include approaches that differentiate between addictive versus problematic sexual problems.

CHAPTER THREE: METHODS

Problematic pornography use, sexual problems, and sexual addiction are increasing worldwide (Price, Patterson, Regnerus, & Walley, 2016), requiring the development and application of EBTs for sexually-related psychopathologies. Further, religious communities are experiencing an increase in problematic sexual behaviors, both addictive and non-addictive (Volk et al., 2017), requiring the implementation of effective treatments that can be accommodated to religious contexts. Religious communities seeking to help members suffering from sexually-related distress have a limited number of treatments available for their use that can be accommodated to the religious setting. The purpose of this study is to determine whether the key components of EBTs are included in the curricula of five faith-based treatments, and whether these faith-based curricula differentiate between addictive versus problematic behaviors. A qualitative inductive content analysis (QICA) is the research design selected for this study.

This chapter reviews the methods used to perform the QICA, beginning with a description of the research design and a justification for its use. Next, a description of the researcher is presented, followed by an explanation of how the data was collected and analyzed. The chapter concludes by addressing the methods used to ensure the trustworthiness of the sources.

Research Design

To date, no known studies have been conducted to examine whether the curricula of these FBTs contain key components of the EBTs shown to be effective for treating sexual addiction. As written in the previous chapters, QICA is the most appropriate method to use when no

previous studies have dealt with a phenomenon (Elo & Kyngäs, 2008). This methodology “allows for an organized systematic analysis of text in order to reveal common elements, themes, and patterns within procedures, and to interpret and make observations of assessed, relevant data” (Chapman et al., 2016). Simply put, QICA provides a systematic and objective method of analyzing and describing the meaning of qualitative data (Elo & Kyngäs, 2008; Schreier, 2014). This analysis is accomplished by assigning consecutive parts of the material to the categories of the coding frame, which is characterized by three key features: data reduction, systematic examination, and flexibility (Schreier, 2014).

QICA differs from other qualitative methods of data analysis in that instead of opening up or adding to the data (Schreier, 2014), QICA helps to condense the amount of material into fewer content-related categories (Elo & Kyngäs, 2008). The researcher is required to focus on specific aspects of meaning that relate to the research question(s) overall (Schreier, 2014) and to theoretically test issues to improve their understanding of the data (Elo & Kyngäs, 2008). The coding frame can contain numerous elements, but the number of these elements is limited by how many categories a researcher is capable of handling (Schreier, 2014). Inherent in this approach is the assumption that when words and/or phrases are classified into the same category, they have the same meaning (Elo & Kyngäs, 2008). This method aims to achieve a condensed yet broad description of the phenomenon, which produces an analysis of the categories that describe the phenomenon.

The second key feature of QICA is its highly systematic method of investigation, which requires examining every part of the material relevant to the research question(s) (Schreier, 2014). This approach reduces the risk of seeing the material strictly from the perspective of one’s prior expectations and assumptions. The method requires the researcher to follow a specific

sequence of steps, irrespective of the research question or material. These steps include: (a) write the research question(s); (b) select the research material; (c) build a coding frame; (d) segment the research material into units; (e) perform trial coding; (f) evaluate the coding frame and modify as needed; (g) perform the main analysis; and (h) report and interpret the findings (Schrier, 2014).

Once the research question is written and the research material is selected, the coding frame is built, and the research material segmented, or divided into units, so each unit can be placed precisely into one subcategory of the coding frame (Schreier, 2014). The coding frame can be modified during the repeated steps of the process, which systematically requires coding to be completed twice for some parts of the material. This ensures the quality of the definitions of the categories and, if the definitions are clear and precise, the second coding results should resemble the results of the first coding.

The third key feature of QICA, and a major benefit of this method, is its flexibility (Schreier, 2014). It generally combines variable sections of concept-driven and data-driven categories inside a single coding frame, at the same time ensuring that a portion of the categories remains data-driven. This provides a safeguard in that the categories match the data; in this way the coding frame not only offers a valid description of the material but also always matches the material. Thus, the purpose of QICA is to produce knowledge and provide new insights through a content-sensitive method that offers flexibility in the research design (Elo & Kyngäs, 2008). QICA is considered a simple technique that does not become entangled in a detailed statistical analysis, and the researcher is directed by the aim and questions of the study.

At the heart of the QICA method is the coding frame, which consists of a minimum of one main category and a minimum of two subcategories (Schreier, 2014). Categories provide a

way to describe, increase understanding of, and generate knowledge about the phenomenon (Elo & Kyngäs, 2008), and the categories include subcategories that specify what the material says about those main categories. A *meaning unit*, or code, identifies words, sentences, or paragraphs that contain related aspects of the content (Graneheim & Lundman, 2004), and fits only one time into one main (sub)category and subcategory. If subcategories are too similar, then is it wise to combine or condense them (Schreier, 2014).

Coding frames must meet several requirements, one of which is that each main category should cover only one aspect of the material (Schreier, 2014). Additionally, the subcategories contained within a main category must be mutually exclusive; one unit can be coded only once per main category, and all pertinent aspects of the material must be included in a category. As the structure of the coding frame is developed, each category must include a name, a description of what that name means, positive examples of the category, and decision rules used to clarify which subcategory to use when subcategories overlap. Creating *themes* provides a way to identify and link recurring underlying meanings together in categories, and themes have been described as threads of meaning that repeatedly occur in various domains, answering the question “How?” (Graneheim & Lundman, 2004).

QICA does not progress in a linear fashion and is more complex and difficult than quantitative analysis; it is also less standardized and formulaic (Schreier, 2014). It does not provide simple guidelines for data analysis, which makes each inquiry distinct and the results dependent on the investigator’s skills, insights, analytic abilities, and style (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). One challenge in using QICA is that it is very flexible and there is no “right” way to do it; this makes the process of analysis challenging, interesting, and an enormous amount of work (Graneheim & Lundman, 2004).

Because this was the first known study to compare the curricula of faith-based ministries to EBTs, there were no previous studies to be considered and no statistics available. Further, no human participants were involved as subjects, so other research designs were not applicable. Thus, QICA was the research design chosen because it was the most suitable method for systematically analyzing the texts of these curricula.

Research Questions

This study sought to answer the following research questions:

1. Are faith-based organizations designing curricula for treating problematic pornography use, sexual problems, and sexual addiction that include the key components of EBTs?
2. To what degree are themes in faith-based ministry curricula for problematic sexual behaviors focused on non-addictive approaches? More specifically, do the current curricula differentiate between addictive and problematic sexual behavior?

Role of the Researcher

Because there were no participants involved in this study, the role of the researcher did not involve any previous relationships with participants or settings. However, as a Licensed Professional Counselor (LPC), this researcher has worked in several professional counseling settings, including private practice, and used several of the EBTs included in this study in the therapeutic process. Additionally, as the wife of a minister currently serving in the ministry, I have observed numerous situations in which Christian ministers reject the idea of using psychoeducation or EBTs to help individuals struggling with mental disorders. During my search

for FBTs, I encountered many ministry websites offering sexual addiction treatment that condemn clinically-based professional approaches to treatment. However, a few ministries were open to EBTs and an increasing number of churches are beginning to recognize the need to establish professional counseling centers within the church, with LPCs as therapists. I approached this study with hopeful optimism that these five FBTs contain some, if not many, components of EBTs.

Data Collection and Analysis Procedures

Data Collection

In the first step of data collection, a therapeutic manual for each EBT was used to identify and list the key components of each EBT. The names of the EBTs and their key components were used to construct the coding system for the study. Each of the five EBTs were used as a main category and its key components were used as the subcategories, which were defined and given codes to identify the EBT and its subcategories. The codes consisted of the abbreviations for the EBTs, followed by a dash, then letter code abbreviations for each subcategory. Coding tables established for each EBT included the name of the EBT, each key component, a code for each key component, and the definition of each key component. (See Tables 3.1-3.5 under Key Component of EBTs.)

An Internet search was performed to identify the faith-based ministries that offer treatment programs for sexual addiction. These ministries were identified by searching Google, Google Scholar, and advanced EBSCO. The primary search terms were “pornography treatment in churches,” “pornography treatment for men,” “pornography treatment for men in churches,” “pornography treatment for women,” “pornography treatment for women in churches,” “sexual

addiction treatment in churches,” “Christian pornography treatments,” and “Christian sexual addiction treatments.” The search results identified websites for churches and faith-based ministries that offered several types of treatment for problems with pornography use, sexual behaviors, and sexual addiction, but most did not involve an established curriculum for use in treatment. Many churches were establishing counseling centers, but their therapeutic approaches were eclectic, meaning that many different approaches were used without an established treatment curriculum. Most of the faith-based ministries offered either long-term residential programs, online group programs, or on-site counseling programs.

Of the five FBT programs selected for this study, three offer on-site treatment programs but also offer their treatment curricula for use in churches. A fourth program is intended for use in churches, and the fifth can be implemented within the church or in any private setting. Data was collected from these five FBT manuals/workbooks that are available for use in churches, and the FBTs were identified as FBT-1, FBT-2, FBT-3, FBT-4, and FBT-5.

For this study, steps one through six, which involved the researcher writing the research questions and building the coding frame from the EBT manuals, were complete. After purchasing the texts and workbooks of the faith-based ministries, the next step called for immersion into the text or workbook of each FBT. This involved reading each FBT text or workbook; writing notes and codes in the margins; and underlining sentences, paragraphs, and pages of information for coding. Because this study focused on using EBTs for individual therapy, some of the chapters and sections of the FBT texts and workbooks were not included, as they are written for family or couples therapy. Additionally, some chapters and sections focused exclusively on Biblical counseling and dealt with an individual’s relationship with God. The

EBTs did not address religious beliefs or activities, so these chapters are covered in Chapter Five of this study.

As I completed this procedure for each FBT curriculum, I set up an individual Excel spreadsheet for each EBT and FBT, with columns for each of the EBT key components. In each key component column, I wrote quotes from the FBT texts or workbooks that indicated the presence of that EBT key component through at least one key term, phrase, or explanation. A blank column signifies that the EBT key component in question is not used by that FBT.

This process continued until all quotes marked in the FBT text or workbook as containing EBT key components had been entered in the EBT spreadsheets. After all quotes had been entered, all FBT codes (FBT-1, FBT-2, FBT-3, FBT-4, FBT-5), EBT codes (EBT-1, EBT-2, EBT-3, EBT-4, EBT-5), EBT key component codes, and quotes were entered in a four-column spreadsheet for ease of tabulation (see Appendices A, B, C, D, and E). All quotes were reviewed a second time to re-evaluate coding and ensure that the quotes matched the codes. The spreadsheets were sent to the researcher's committee chair, who also reviewed the coding.

Data Analysis

Once the coding was rechecked, the columns were tabulated. A total count was made of each EBT key component used by each FBT curriculum. When this was completed, the frequency count of each EBT key component was written in the corresponding EBT Coding Sheet and listed in the Frequency Count column to show which, if any, EBT components were used by FBT curricula.

Key components of the five evidence-based therapies. The key components from the treatment manual of each EBT (CBT, BPT, MI, GT, and MBT) were identified and used as the coding frame for comparison with the components of each FBT. The EBTs and FBTs are listed

below. These comparison exercises determined whether the EBT components: (a) apply, (b) could be applied, or (c) are not applicable to each component in the faith-based curricula. This comparison also explained how each component applied or could apply to EBT components.

After this comparison was completed, a summary was presented for each FBT that identified which EBT components were present in that FBT. This answered Research Question #1, which asked whether EBT components were included the FBT treatments and whether those EBT components contributed to the effectiveness of those treatments. The key components of each EBT are listed in the tables below, followed by a brief description of each of the faith-based ministries.

Table 3.1

Cognitive Behavioral Therapy Key Components

Components	Codes	Definitions
Individual Psychotherapy	CBT-IT	Psychotherapy session with a therapist and a client
Therapeutic Alliance	CBT-TA	Development of a strong therapist-client relationship built on empathy, genuineness, and positive regard
Psychoeducation	CBT-PED	Orientation of the client to the theory, structure, content, and expectations of CBT that provides information about the presenting problem and how it will be treated
Assessment	CBT-ASM	Evaluation of client concerns and difficulties using assessment tools and the ABC model
Collaborative Goals & Treatment Plan	CBT-CGTP	Identification of observable, measurable, and achievable collaborative goals for therapy
Intervention Techniques & Homework	CBT-ITH	Assignment of reading, behavior monitoring, and practicing skills between sessions
Dysfunctional Core Beliefs & Thoughts	CBT-DCBT	Core beliefs formed during childhood that influence and distort one's perceptions of experiences and one's beliefs about oneself
Challenge Dysfunctional Core Beliefs & Thoughts	CBT-CDCBT	Nonjudgmental questions that challenge the client's dysfunctional thoughts and beliefs
Behavior Activation	CBT-BA	Set of procedures or techniques aimed at increasing client activity; reinforces situations that improve mood and functioning
Problem Solving	CBT-PS	Identification of effective coping skills to deal with presenting problem(s)
Relaxation	CBT-RLX	Psychotherapeutic techniques for reducing stress, worry, and/or anxiety
Ending Treatment/Relapse Prevention	CBT-ETRP	End-of-treatment collaborative plan to prepare the client to anticipate and cope with potential stressors and symptoms

Cully, J. A., & Teten, A. L. (2008). *A therapist's guide to brief cognitive behavioral therapy*. Houston, TX: Department of Veterans Affairs South Central MIRECC.

Table 3.2

Brief Psychodynamic Therapy Key Components

Components	Codes	Definitions
Individual Psychotherapy	BPT-IP	Psychotherapy session with therapist and client
Therapeutic Alliance	BBT-TA	Development of a strong therapist-client relationship built on empathy, genuineness, and positive regard, in which the therapist is actively involved in the session
Developmental Functioning Level	BPT-DFL	Determination of the stage of development at which the client is currently functioning
Main Therapy Goal	BPT-MTG	Identification of one key goal for therapy
Unconscious Core Beliefs	BPT-UCB	Unconscious core conflicts developed as a result of early childhood experiences, which lie at the heart of the client's problems
Client Insight	BPT-CI	Thoughts and feelings that lead to the realization and understanding of oneself, one's internal processes, and/or one's behavior, and that lead to change
Defense Mechanisms	BPT-DM	Constructs of the ego that operate to minimize pain and strive to maintain the psyche's equilibrium
Transference	BPT-TR	Transferring of key unresolved conflicts with others onto the therapist

Center for Substance Abuse Treatment. (1999). *Brief interventions and brief therapies for substance abuse*. Rockville, MD: Substance Abuse and Mental Health Services Administration (US). (Treatment Improvement Protocol (TIP) Series, No. 34.) Chapter 7—Brief Psychodynamic Therapy. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64952/>

Table 3.3

Motivational Interviewing Key Components

Components	Codes	Definitions
Therapeutic Partnership	MI-TP	Therapist establishes an active collaboration “for” and “with” the client
Acceptance	M-AC	Therapist expresses unconditional positive regard and empathy, honors autonomy, and affirms the client
Compassion	MI-CO	Therapist promotes the client’s welfare and needs
Evocation	MI-EV	Therapist evokes/brings out the client’s thoughts and arguments for change
Engaging	MI-EN	Therapist and client establish a connection and working relationship
Focusing	MI-FO	Therapist develops the conversation to move in the direction of changing behavior
Evoking	MI-EK	Therapist elicits the client’s own argument/motivation to change the behavior once the goal is clarified
Planning	MI-PL	Therapist and client form a plan of action to change behaviors once the client is ready to commit to change
Open-Ended Questions	MI-OEQ	Therapist asks the client open-ended questions to keep the communication flowing
Affirmation	MI-AF	Therapist reinforces the client’s strengths, positive steps, and intentions in the proper direction
Reflective Listening	MI-RL	Therapist restates the client’s thoughts and feelings, allowing the client to rehear and ponder those words differently
Summarizing	MKI-SU	Therapist reflects and validates the client’s words to show that he/she has been listening, remembering, and valuing the client’s words
Precontemplation Stage	MI-PCS	Client views change as unwanted, unneeded, irrelevant, or impossible to accomplish
Contemplation Stage	MI-CS	Client examines problematic behavior/considers change on a risk-reward basis
Preparation Stage	MI-PPS	Client makes a commitment to change and develops a plan for making the change
Action Stage	MI-AS	Client implements a plan to change present negative behavior and start a new behavioral pattern
Maintenance Stage	MI-MS	Client sustains the new behavior for a prolonged period, integrating it into his/her lifestyle

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

DiClemente, C. C. (2006). *Addiction and change: How addictions develop and addicted people recover*. New York, NY: Guilford Press.

Table 3.4

Group Therapy Key Components

Components	Codes	Definitions
Group Members	GT-GM	Clients identified as suitable candidates for the group's purpose
Group Leader/Therapist	GT-GLT	Therapist trained in individual and group therapy, responsible for determining group size, gender, type of client, and open or closed group
Group Purpose	GT-GP	Group's specific reason for meeting, and group goals and objectives. Members meet only during sessions
Confidentiality	GT-CN	Rule that group members' statements are not to be shared outside the confines of the session
Structure	GT-ST	Stages, boundaries, and rules for group attendance, participation, communication, etc.
Group/Individual Goals	GT-GIG	Identified goals to be achieved by individual clients and the group
Open/Closed Group	GT-OCG	Type of group: <i>Open group</i> maintains size by admitting new members as members leave; <i>closed group</i> admits no new members once the group has begun
Open/Honest Talk/Self-Disclosure	GT-OTSD	Personal sharing of perspectives or information that would not be shared in normal, daily social situations
Relationship Building	GT-RB	Establishment and maintenance of relationships that assist in managing behaviors
Social Support	GT-SS	Development of close bonds with others dealing with similar problems
Interpersonal Conflicts	GT-IC	Conflicts between group members
Examine Addictive Process	GT-EAP	Examination of group members' thoughts and feelings to help with issues and concerns
Initial/Beginning Stage	GT-BS	Stage in which group members introduce themselves and establish group norms, goals, and supervision by the therapist
Middle/Working Stage	GT-WS	Stage in which the group focuses on achieving its purpose and establishes cohesion, balance, trust, and cooperation; members gain comfort with self-disclosure; and the group benefits from members' participation
Closing/Ending Stage	GT-ES	Stage in which the group's purpose has been accomplished and members' needs have been met, and the group terminates

Brabender, V. A., Fallon, A. E., & Smolar, A. I. (2004). *Essentials of group therapy*. Hoboken, NJ: John Wiley & Sons, Inc.
 Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). Boulder, CO: Basic Books.

Table 3.5

Mindfulness-Based Cognitive Therapy Key Components

Components	Codes	Definitions
Focus on Present Moment, Awareness, and Acceptance	MBCT-FPMA	Emphasis on awareness of the present moment; external triggers; and patterns of emotional, cognitive, and behavioral reactions. Focus is on awareness of the process and nature of thought, not on challenging its content
Nonjudgmental	MBCT-NJ	No judgments are made; void of moral values or beliefs
Non-Religious Meditation	MBCT-NRM	Contemporary psychological application of the clinical aspects of mindfulness practices in a secular context
Expect/Tolerate Problematic Experiences	MBCT-ETPE	By observing sexually-related thought, clients examine cognitive processes related to triggers, urges, and cravings and reframe problematic experiences to become expected and tolerable
Reflect, Do Not React	MBCT-RDNR	Client learns to stay with the discomfort and pause before engaging in reactive behavior, regardless of the situation/content, then let go of the thought and return to observing passing thought(s)
Stress Reduction	MBCT-SR	Client learns to identify the underlying urge or craving to meet the need more skillfully and effectively. Practices are “intended to liberate the practitioner and allow him or her to shift away from cognitive and behavioral patterns that lead to suffering . . . craving is a natural phenomenon that must be understood and accepted” (p. 514).
Breathing Exercises	MBCT-BE	SOBER — S top O bserve B reathe E xpand R espond—is a practice that focuses on breathing and fosters awareness of rumination, automatic thinking, emotions, and sensations, prompting a shift to more nonjudgmental, present-focused thinking
Coping Skills/Exercise Homework	MBCT-CSEH	Practices that “target tolerance of negative physical, emotional, and cognitive states, thereby decreasing the need to alleviate discomfort by engaging in impulsive behavior.” (p. 515)
Relapse Prevention	MBCT-RP	“Intervention applied with an individual in the recovery/maintenance phase of addiction that focuses on skill building to prevent the reoccurrence of the addictive behavior.” (p. 521)

Witkiewitz, K., Bowen, S., Harrop, E. N., Douglas, H., Enkema, M., & Sedgwick, C. (2014). Mindfulness-based treatment to prevent addictive behavior relapse: Theoretical models and hypothesized mechanisms of change. *Substance Use & Misuse*, 49, 513-524. doi: 10.3109/10826084.2014.891845

Faith-based ministries offering sexual addiction treatment. Each faith-based ministry is coded as a faith-based treatment (FBT) and numbered as FBT-1, FBT-2, FBT-3, FBT-4, and FBT-5.

FBT-1. FBT-1 is a nationally recognized sexual addiction treatment center and was the first sexual addiction treatment center created for women. It has now expanded its programs to include treatment for men, couples, and adolescent females. Its primary approach is intensive workshops conducted by LPCs with at least a master's degree. There is a charge for the workshops. According to FBT-1's website, the organization uses a trauma-based treatment model and an eclectic therapeutic approach, which includes CBT, GT, and other empirically-supported treatments. It also offers specialized training in the treatment of sexual addiction for mental health professionals.

FBT-2. FBT-2 is a Christian counseling center that specializes in sexual addiction treatment for men, support for wives, and help for couples. The director has a Ph.D. and is considered one of the Christian leaders in sex addiction therapy; his wife has a master's degree and is a Licensed Marriage and Family Therapist (LMFT). The center offers a 3-Day Intensive Workshop for treating sexual addiction that involves group counseling and employs various therapeutic techniques. There is a charge for the workshop. The center's therapeutic manual and workbook are available for purchase to be used in local church ministries.

FBT-3. FBT-3 is a ministry that provides sexual addiction treatment for men through one-on-one accountability. It also works with small men's groups in churches using the FBT-3 program. The organization offers a 12-week Workbook Study to overcome sexual addiction. Additionally, it offers support for wives of men with sexual addiction. There is a charge for these

resources. The ministry uses a Biblical-counseling approach, and there is no statement about professional training or licensed counselors.

FBT-4. FBT-4 is a clinical counseling program that is Biblically based and uses clinically-informed treatment for individuals, couples, and families dealing with sexual addiction. According to its website, the program uses an addiction model and treatment is conducted through a 12-month program, of which 75% is done through secure online video conferencing. There is a charge for these services. Its clinicians are certified through the International Institute for Trauma and Addiction Professionals (IITAP), which is based in Arizona and founded by Patrick Carnes for specialized sexual addiction training. FBT-4's clinicians are either Certified Sex Addiction Therapists or Pastoral Sex Addiction Professionals. The program also offers its curriculum to local churches that want to start a sexual addiction counseling ministry.

FBT-5. FBT-5 is a 12-step recovery group program for sexual addiction that is based on the principles and traditions of Alcoholics Anonymous. It offers a group meeting open to men and women who desire to overcome their sexual addiction and are willing to share their experiences, strength, and hope with others to solve a shared problem. The sole criterion for membership in the group is that individuals desire to become sexually sober and stop lusting. FBT-5 requires no dues or fees. The program's primary purpose is to help sex addicts stay sexually sober and to offer a support group to help others achieve sexual sobriety. According to FBT-5's principles, a group consists of two or more sexually addicted individuals who gather together for purposes of sexual sobriety. This program uses no professionally trained or licensed counselors. There is no charge to join.

Methods to Address Trustworthiness

It is vital that research findings be as trustworthy as possible (Graneheim & Lundman, 2004). The aim of trustworthiness is give support to the argument that the findings of the study as accurate and “worth paying attention to” (Elo, Kaariainen, Kanste, Polkki, Utriainen, & Kyngas, 2014, p. 2.). The definition of trustworthiness differs in the quantitative and qualitative research traditions. The tradition of quantitative content analysis identifies *validity*, *reliability*, and *generalizability* as characteristics of a trustworthy research study (Downe-Wamboldt, 1992; Olson et al., 1998; Shields & King, 2001). In contrast, the concepts of *credibility*, *dependability*, *transferability*, and *confirmability* are used to describe trustworthiness in qualitative research (Graneheim & Lundman, 2004; Lincoln & Guba, 1985; Polit & Hungler, 1999).

Credibility in qualitative research refers to the degree of confidence in a study related to “making a decision about the focus of study, selection of context, participants and approach to gathering data” (Graneheim & Lundman, 2004, p. 109). The most suitable method for data collection must be chosen and to ensure that the proper amount of data is collected. Credibility also refers to the need to encompass all relevant data within the identified categories and themes, such that no relevant data was systematically excluded, nor irrelevant data included. Credibility involves recognizing similarities within categories as well as differences between them, as demonstrated through the use of representative quotations from the transcribed text. This study involves no participants or settings, focusing instead on established curricular texts and workbooks from which quotes containing EBT key components are extracted, thus establishing credibility.

Dependability, another aspect of trustworthiness, addresses the degree to which data has changed over time and how the researcher’s decisions themselves may have changed in the

course of the analysis process (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). Such changes can create inconsistencies when data collection is extensive and occurs over time. In this study, the materials are well established, copyrighted EBT and FBT curricula, which have not changed over time and establish dependability.

Transferability refers to the extent that a study's findings can be used by, or transferred to, other groups or settings (Graneheim & Lundman, 2004; Polit & Hungler, 1999). To support transferability, a study must provide clear and detailed information regarding culture, context, and participant selection and characteristics, as well as thorough descriptions of data collection and analysis. This study's findings can be transferred to any other group or setting. Finally, *confirmability* deals with the presentation, objectivity, and/or neutrality of the data (Bengtsson, 2016), and that two or more independent people agree on the accuracy, relevance, and/or meaning of the data (Elo et al., 2014).

CHAPTER FOUR: DATA ANALYSIS AND RESULTS

The purpose of this study was to determine whether the key components of EBTs are included in the curricula of five faith-based treatments, and whether these faith-based curricula differentiate between addictive versus problematic behaviors. Chapter Three presented a detailed summary of the process used to gather, collect, and analyze data from the treatment manuals of the five EBTs and the five FBTs. The EBT treatment manuals identified the key components of each EBT. These key components were organized and used to develop the coding frame to which the FBT manuals were compared.

Additionally, the treatment manuals for each of the FBTs were reviewed thoroughly to identify any EBT key components that were included. This procedure involved looking specifically for key terms, phrases, and explanations that described those key components. As these terms, phrases, and explanations were identified, quotes from each FBT manual that contained EBT components were written in the coding frame tables. This process followed Schreier's (2014) eight-step procedure for conducting a QICA study.

Chapter One of this study introduced contemporary problems confronting society and the church/religious community as a result of pornography use, sexual problems, and sexual addiction. Chapter Two provided a thorough review of the existing literature on behavioral addictions, including sexual addiction, and offered evidence supporting the efficacy of EBTs in treating sexual addiction. Chapter Three described the study's design, research questions, and procedures for collecting and analyzing data, and discussed the trustworthiness of the study.

This chapter presents the findings that emerged from an intensive comparison of the EBT key components to the FBT curricula, which identified the presence of EBT key components in

those curricula. As noted in Chapter Three, some of the material in these FBT manuals was not reviewed because it addressed topics that are beyond the scope of this study, such as family systems and couples therapy. Due to the large volume of information involved in reporting QICA results, Bengtsson (2016) and Schreier (2014) both recommend using tables rather than continuous text to present QICA findings, providing readers greater ease in reviewing the results. Thus, the findings for each FBT with CBT, BPT, MI, GT, and MBCT are summarized below, along with the answers to the two research questions. Following the summaries are tables that present the results regarding use of EBT key components, one or two sample quotes that verify the presence of these components, and the frequency of use count for the key components in each FBT.

Results

The results of the QICA are given below and listed under each FBT. (See findings in Tables 4.1-4.5 below)

FBT-1

FBT-1's approach to therapy is GT, and it encourages individual psychotherapy along with group counseling.

CBT results. The QICA yielded the following results regarding the use of CBT key components: (a) individual psychotherapy = 4; (b) therapeutic alliance = 13; (c) psychoeducation = 7; (d) assessment = 10; (e) collaborative goals and treatment plan = 2; (f) intervention techniques and homework = 3; (g) dysfunctional core beliefs and thoughts = 11; (h) challenge dysfunctional core beliefs and thoughts = 2; (i) behavior activation = 1; (j) problem solving = 1; (k) relaxation = 0; and (l) end of treatment/relapse prevention = 12. In the manual for FBT-1, 11

of 12 key components of CBT were used at least once. The missing component was relaxation, but that component was included in the exercises for another EBT. (See Table 4.1 for results.)

BPT results. The QICA yielded the following results regarding use of BPT key components: (a) individual psychotherapy = 4; (b) therapeutic alliance = 13; (c) developmental functioning level = 2; (d) main therapeutic goal = 1; (e) unconscious core beliefs = 11; (f) client insight = 1; (g) defense mechanisms = 1; and (h) transference = 2. In the manual for FBT-1, all eight of the key components of BPT were used at least one time. (See Table 4.2 for results)

MI results. The QICA yielded the following results regarding use of MI key components: (a) therapeutic partnership = 0; (b) acceptance = 0; (c) compassion = 0; (d) evocation = 0; (e) engaging = 0; (f) focusing = 0; (g) evoking = 0; (h) planning = 0; (i) open-ended questions = 0; (j) affirmation = 0; (k) reflective listening = 0; (l) summarizing = 0; (m) precontemplation stage = 2; (n) contemplation stage = 1; (o) preparation stage = 1; (p) action stage = 1; and (q) maintenance stage = 1. In the manual for FBT-1, four of the 17 key components of MI were used at least one time. (See Table 4.3 for results.)

GT results. The QICA yielded the following results regarding use of GT key components: (a) group members = 0; (b) group leader/therapist = 1; (c) group purpose = 3; (d) confidentiality = 2; (e) structure = 4; (f) group/individual goals = 1; (g) open/closed groups = 5; (h) open talk/self-disclosure = 1; (i) relationship building = 1; (j) social support = 3; (k) interpersonal conflicts = 0; (l) examine addictive process = 5; (m) beginning stage = 1; (n) working stage = 1; and (o) ending stage = 3. In the manual for FBT-1, 11 of the 12 key components for GT were used at least one time. The key component not used was group members. (See Table 4.4 for results.)

MBCT results. The QICA yielded the following results regarding use of MBCT key components: (a) focus on present moment, awareness, and acceptance = 3; (b) nonjudgmental = 0; (c) non-religious meditation = 0; (d) expect/tolerate problematic experiences = 0; (e) reflect, do not react = 0; (f) stress reduction = 1; (g) breathing exercises = 1; (h) coping skills/exercise homework = 4; and (i) relapse prevention = 1. In the manual for FBT-1, five of the nine key components of MBCT were used at least one time. (See Table 4.5 for results.)

FBT-2

FBT-2's approach to therapy is the 12-step program and it discourages individual psychotherapy for sexual addiction.

CBT results. The QICA yielded the following results regarding use of CBT key components: (a) individual psychotherapy = 3; (b) therapeutic alliance = 0; (c) psychoeducation = 4; (d) assessment = 4; (e) collaborative goals and treatment plan = 0; (f) intervention techniques and homework = 10; (g) dysfunctional core beliefs and thoughts = 30; (h) challenge dysfunctional core beliefs and thoughts = 7; (i) behavior activation = 14; (j) problem solving = 7; (k) relaxation = 0; and (l) end of treatment/relapse prevention = 10. In the manual for FBT-2, nine of the 12 key components of GT were used at least one time. (See Table 4.1 for results.)

BPT results. The QICA yielded the following results regarding use of BPT key components: (a) individual psychotherapy = 3; (b) therapeutic alliance = 0; (c) developmental functioning level = 2; (d) main therapeutic goal = 1; (e) unconscious core beliefs = 12; (f) client insight = 1; (g) defense mechanisms = 10; and (h) transference = 0. In the manual for FBT-2, six of the eight key components of BPT were used at least one time. (See Table 4.2 for results.)

MI results. The QICA yielded the following results regarding use of MI key components: (a) therapeutic partnership = 0; (b) acceptance = 0; (c) compassion = 0; (d)

evocation = 0; (e) engaging = 0; (f) focusing = 0; (g) evoking = 0; (h) planning = 0; (i) open-ended questions = 0; (j) affirmation = 0; (k) reflective listening = 0; (l) summarizing = 0; (m) precontemplation stage = 0; (n) contemplation stage = 0; (o) preparation stage = 0; (p) action stage = 0; and (q) maintenance stage = 0. In the manual for FBT-2, none of the eight key components of MI were used. (See Table 4.3 for results.)

GT results. The QICA yielded the following results for FBT-2 regarding use of GT key components: (a) group members = 2; (b) group leader/therapist = 1; (c) group purpose = 1; (d) confidentiality = 1; (e) structure = 2; (f) group/individual goals = 1; (g) open/closed groups = 0; (h) open talk/self-disclosure = 8; (i) relationship building = 6; (j) social support = 11; (k) interpersonal conflicts = 1; (l) examine addictive process = 7; (m) beginning stage = 0; (n) working stage = 0; and (o) ending stage = 0. In the manual for FBT-2, 11 of the 15 key components of GT were used at least one time. (See Table 4.4 for results.)

MBCT results. The QICA yielded the following results regarding use of MBCT key components: (a) focus on present moment, awareness, and acceptance = 0; (b) nonjudgmental = 0; (c) non-religious meditation = 0; (d) expect/tolerate problematic experiences = 0; (e) reflect, do not react = 0; (f) stress reduction = 0; (g) breathing exercises = 0; (h) coping skills/exercise homework = 0; and (i) relapse prevention = 0. In the manual for FBT-2, none of the nine key components of MBCT were used. (See Table 4.5 for results.)

FBT-3

FBT-3's approach is a one-on-one accountability program for men and small groups in churches.

CBT results. The QICA yielded the following results regarding use of CBT key components: (a) individual psychotherapy = 0; (b) therapeutic alliance = 0; (c) psychoeducation

= 4; (d) assessment = 0; (e) collaborative goals and treatment plan = 0; (f) intervention techniques and homework = 0; (g) dysfunctional core beliefs and thoughts = 47; (h) challenge dysfunctional core beliefs and thoughts = 8; (i) behavior activation = 24; (j) problem solving = 10; (k) relaxation = 0; and (l) end of treatment/relapse prevention = 0. In the manual for FBT-3, five of the 12 key components of CBT were used at least one time. (See Table 4.1 for results.)

BPT results. The QICA yielded the following results regarding use of BPT key components: (a) individual psychotherapy = 0; (b) therapeutic alliance = 0; (c) developmental functioning level = 0; (d) main therapeutic goal = 1; (e) unconscious core beliefs = 49; (f) client insight = 0; (g) defense mechanisms = 0; and (h) transference = 0. In the manual for FBT-3, five of the 12 key components of BPT were used at least one time. (See Table 4.2 for results.)

MI results. The QICA yielded the following results regarding use of MI key components: (a) therapeutic partnership = 0; (b) acceptance = 0; (c) compassion = 0; (d) evocation = 0; (e) engaging = 0; (f) focusing = 0; (g) evoking = 0; (h) planning = 0; (i) open-ended questions = 0; (j) affirmation = 0; (k) reflective listening = 0; (l) summarizing = 0; (m) precontemplation stage = 0; (n) contemplation stage = 0; (o) preparation stage = 0; (p) action stage = 0; and (q) maintenance stage = 0. In the FBT-3 manual, none of the 17 key components of MI were used. (See Table 4.3 for results.)

GT results. The QICA yielded the following results regarding use of GT key components: (a) group members = 0; (b) group leader/therapist = 0; (c) group purpose = 1; (d) confidentiality = 0; (e) structure = 0; (f) group/individual goals = 0; (g) open/closed groups = 0; (h) open talk/self-disclosure = 3; (i) relationship building = 4; (j) social support = 5; (k) interpersonal conflicts = 0; (l) examine addictive process = 0; (m) beginning stage = 0; (n)

working stage = 0; and (o) ending stage = 0. In the FBT-3 manual, five of the 15 key components of GT were used at least one time. (See Table 4.4 for results.)

MBCT results. The QICA yielded the following results regarding use of MBCT key components: (a) focus on present moment, awareness, and acceptance = 0; (b) nonjudgmental = 0; (c) non-religious meditation = 0; (d) expect/tolerate problematic experiences = 0; (e) reflect, do not react = 0; (f) stress reduction = 0; (g) breathing exercises = 0; (h) coping skills/exercise homework = 0; and (i) relapse prevention = 0. In the FBT-3 manual, none of the nine key components of MBCT were used. (See Table 4.5 for results.)

FBT-4

FBT-4 is a clinical counseling program that uses a 12-step program and clinically-informed treatments for individuals, couples, and families who deal with sexual addiction.

CBT results. The QICA yielded the following results regarding use of CBT key components: (a) individual psychotherapy = 1; (b) therapeutic alliance = 0; (c) psychoeducation = 26; (d) assessment = 3; (e) collaborative goals and treatment plan = 0; (f) intervention techniques and homework = 1; (g) dysfunctional core beliefs and thoughts = 32; (h) challenge dysfunctional core beliefs and thoughts = 0; (i) behavior activation = 4; (j) problem solving = 7; (k) relaxation = 0; and (l) end of treatment/relapse prevention = 7. In the FBT-4 manual, eight of the 12 key components of CBT were used at least one time. (See Table 4.1 for results.)

BPT results. The QICA yielded the following results regarding use of BPT key components: (a) individual psychotherapy = 0; (b) therapeutic alliance = 0; (c) developmental functioning level = 0; (d) main therapeutic goal = 0; (e) unconscious core beliefs = 1; (f) client insight = 0; (g) defense mechanisms = 6; and (h) transference = 1. In the FBT-4 manual, three of the eight key components of BPT were used at least one time. (See Table 4.2 for results.)

MI results. The QICA yielded the following results regarding use of MI key components: (a) therapeutic partnership = 0; (b) acceptance = 0; (c) compassion = 0; (d) evocation = 0; (e) engaging = 0; (f) focusing = 0; (g) evoking = 0; (h) planning = 0; (i) open-ended questions = 0; (j) affirmation = 0; (k) reflective listening = 0; (l) summarizing = 0; (m) precontemplation stage = 0; (n) contemplation stage = 0; (o) preparation stage = 0; (p) action stage = 0; and (q) maintenance stage = 0. In the FBT-4 manual, none of the 17 key components of MI were used. (See Table 4.3 for results.)

GT results. The QICA yielded the following results regarding use of GT key components: (a) group members = 0; (b) group leader/therapist = 1; (c) group purpose = 1; (d) confidentiality = 1; (e) structure = 4; (f) group/individual goals = 0; (g) open/closed groups = 1; (h) open talk/self-disclosure = 4; (i) relationship building = 4; (j) social support = 6; (k) interpersonal conflicts = 0; (l) examine addictive process = 4; (m) beginning stage = 0; (n) working stage = 0; and (o) ending stage = 0. In the FBT-4 manual, eight of the 15 key components of GT were used at least once. (See Table 4.4 for results.)

MBCT results. The QICA yielded the following results regarding use of MBCT key components: (a) focus on present moment, awareness, and acceptance = 3; (b) nonjudgmental = 0; (c) non-religious meditation = 0; (d) expect/tolerate problematic experiences = 0; (e) reflect, do not react = 0; (f) stress reduction = 0; (g) breathing exercises = 0; (h) coping skills/exercise homework = 0; and (i) relapse prevention = 0. In the FBT-4 manual, one of the 9 key components of MBCT was used at least one time. (See Table 4.5 for results.)

FBT-5

FBT-5 is a 12-step recovery group program for sexual addiction that is based on Alcoholics Anonymous principles and traditions.

CBT results. The QICA yielded the following results regarding use of CBT key components: (a) individual psychotherapy = 0; (b) therapeutic alliance = 0; (c) psychoeducation = 10; (d) assessment = 0; (e) collaborative goals and treatment plan = 0; (f) intervention techniques and homework = 2; (g) dysfunctional core beliefs and thoughts = 23; (h) challenge dysfunctional core beliefs and thoughts = 2; (i) behavior activation = 1; (j) problem solving = 4; (k) relaxation = 0; and (l) end of treatment/relapse prevention = 0. In the FBT-5 manual, five of the 12 key components of CBT were used at least one time. (See Table 4.1 for results.)

BPT results. The QICA yielded the following results regarding use of BPT key components: (a) individual psychotherapy = 0; (b) therapeutic alliance = 0; (c) developmental functioning level = 3; (d) main therapeutic goal = 0; (e) unconscious core beliefs = 24; (f) client insight = 3; (g) defense mechanisms = 10; and (h) transference = 0. In the FBT-5 manual, four of the eight key components of BPT were used at least one time. (See Table 4.2 for results.)

MI results. The QICA yielded the following results regarding use of MI key components: (a) therapeutic partnership = 0; (b) acceptance = 0; (c) compassion = 0; (d) evocation = 0; (e) engaging = 0; (f) focusing = 0; (g) evoking = 0; (h) planning = 0; (i) open-ended questions = 0; (j) affirmation = 0; (k) reflective listening = 0; (l) summarizing = 0; (m) precontemplation stage = 0; (n) contemplation stage = 0; (o) preparation stage = 0; (p) action stage = 0; and (q) maintenance stage = 0. In the FBT-5 manual, none of the 17 key components of MI were used. (See Table 4.3 for results.)

GT results. The QICA yielded the following results regarding use of GT key components: (a) group members = 2; (b) group leader/therapist = 2; (c) group purpose = 2; (d) confidentiality = 1; (e) structure = 17; (f) group/individual goals = 2; (g) open/closed groups = 1; (h) open talk/self-disclosure = 3; (i) relationship building = 4; (j) social support = 7; (k)

interpersonal conflicts = 0; (l) examine addictive process = 24; (m) beginning stage = 1; (n) working stage = 0; and (o) ending stage = 0. In the FBT-5 manual, 12 of the 15 key components of GT were used at least one time. (See Table 4.4 for results.)

MBCT results. The QICA yielded the following results regarding use of MBCT key components: (a) focus on present moment, awareness, and acceptance = 0; (b) nonjudgmental = 0; (c) non-religious meditation = 0; (d) expect/tolerate problematic experiences = 0; (e) reflect, do not react = 0; (f) stress reduction = 0; (g) breathing exercises = 0; (h) coping skills/exercise homework = 0; and (i) relapse prevention = 0. In the FBT-5 manual, none of the nine key components of MBCT were used. (See Table 4.5 for results.)

Table 4.1

Cognitive Behavior Therapy Key Components Used in FBTs

Components	Codes	Definitions	FBT- 1	FBT- 2	FBT- 3	FBT- 4	FBT- 5
Individual Psychotherapy	CBT-IT	Psychotherapy session with a therapist and a client	4	3	-	1	-
Therapeutic Alliance	CBT-TA	Development of a strong therapist-client relationship built on empathy, genuineness, and positive regard	13	-	-	-	-
Psychoeducation	CBT-PED	Orientation of the client to the theory, structure, content, and expectations of CBT that provides information about the presenting problem and how it will be treated	7	4	4	26	10
Assessment	CBT-ASM	Evaluation of client concerns and difficulties using assessment tools and the ABC model	10	4	-	3	-
Collaborative Goals & Treatment Plan	CBT-CGTP	Identification of observable, measurable, and achievable collaborative goals for therapy	2	-	-	-	-
Intervention Techniques & Homework	CBT-ITH	Assignment of reading, behavior monitoring, and practicing skills between sessions	3	10	-	1	2
Dysfunctional Core Beliefs & Thoughts	CBT-DCBT	Core beliefs formed during childhood that influence and distort one's perceptions of experiences and beliefs about oneself	11	30	47	32	23
Challenge Dysfunctional Core Beliefs & Thoughts	CBT-CDCBT	Nonjudgmental questions that challenge the client's dysfunctional thoughts and beliefs	2	7	8	-	2
Behavior Activation	CBT-BA	Set of procedures and techniques aimed at	1	14	24	4	1

		increasing client activity; reinforces situations that improve mood and functioning					
Problem Solving	CBT-PS	Identification of effective coping skills to deal with presenting problem(s)	1	7	10	7	4
Relaxation	CBT-RLX	Psychotherapeutic techniques for reducing stress, worry, and/or anxiety	-	-	-	-	-
Ending Treatment-Relapse Prevention	CBT-ETRP	End-of-treatment collaborative plan to prepare the client to anticipate and cope with potential stressors and symptoms	12	10	-	7	-

Table 4.2

Brief Psychodynamic Therapy Key Components Used in FBTs

Components	Codes	Definitions	FBT- 1	FBT- 2	FBT- 3	FBT- 4	FBT- 5
Individual psychotherapy	BPT-IP	Psychotherapy session with therapist and client	4	3	-	-	-
Therapeutic Alliance	BPT-TA	Development of a strong therapist-client relationship built on empathy, genuineness, and positive regard, in which the therapist is actively involved in the session	13	-	-	-	-
Developmental Functioning Level	BPT-DFL	Determination of the stage of development at which the client is currently functioning	2	2	-	-	3
Main Therapeutic Goal	BPT-MTG	Identification of one key goal for therapy	1	1	1	-	-
Unconscious Core Beliefs	BPT-UCB	Unconscious core conflicts developed because of early childhood experiences, which lie at the heart of the client's problems	11	12	49	1	24
Client Insight	BPT-CI	Thoughts and feelings that lead to the realization and understanding of oneself, one's internal processes, and/or one's behavior, and that lead to change	1	1	-	-	3
Defense Mechanisms	BPT-DM	Constructs of the ego that operate to minimize pain and strive to maintain the psyche's equilibrium	1	10	-	6	10
Transference	BPT-TR	Transferring of key unresolved conflicts with others onto the therapist	2	-	-	1	-

Table 4.3

Motivational Interviewing Key Components Used in FBTs

Components	Codes	Definitions	FBT- 1	FBT- 2	FBT- 3	FBT- 4	FBT- 5
Therapeutic Partnership	MI-TP	Therapist establishes an active collaboration “for” and “with” the client	-	-	-	-	-
Acceptance	MI-AC	Therapist expresses unconditional positive regard and empathy, honors autonomy, and affirms the client	-	-	-	-	-
Compassion	MI-CO	Therapist promotes the client’s welfare and needs	-	-	-	-	-
Evocation	MI-EV	Therapist evokes/brings out the client’s thoughts and arguments for change	-	-	-	-	-
Engaging	MI-EN	Therapist and client establish a connection and working relationship	-	-	-	-	-
Focusing	MI-FO	Therapist develops the conversation to move in the direction of changing behavior	-	-	-	-	-
Evoking	MI-EV	Therapist elicits the client’s own argument/motivation to change the behavior once the goal is clarified	-	-	-	-	-
Planning	MI-PL	Therapist and client form a plan of action to change behaviors once the client is ready to commit to change	-	-	-	-	-
Open-ended Questions	MI-OEQ	Therapist asks the client open-ended questions to keep the communication flowing	-	-	-	-	-
Affirmation	MI-AF	Therapist reinforces the client’s strengths, positive steps, and intentions in the proper direction	-	-	-	-	-
Reflective Listening	MI-RL	Therapist restates the client’s thoughts and feelings, allowing the client to rehear and ponder those words differently	-	-	-	-	-
Summarizing	MI-SU	Therapist reflects and validates the client’s words to show that he/she has been listening, remembering, and valuing the client’s words	-	-	-	-	-
Precontemplation Stage	MI-PCS	Client views change as unwanted, unneeded, irrelevant, or impossible to accomplish	2	-	-	-	-
Contemplation Stage	MI-CS	Client examines problematic behavior/considers change on a risk-reward basis	1	-	-	-	-

Preparation Stage	MI-PPS	Client makes a commitment to change and develops a plan for making the change	1	-	-	-	-
Action Stage	MI-AS	Client implements a plan to change present negative behavior and start a new behavioral pattern	1	-	-	-	-
Maintenance Stage	MI-MS	Client sustains the new behavior for a prolonged period, integrating it into his/her lifestyle	1	-	-	-	-

Table 4.4

Group Therapy Key Components Used in FBTs

Components	Codes	Definitions	FBT- 1	FBT- 2	FBT- 3	FBT- 4	FBT- 5
Group Members	GT-GM	Clients identified as suitable candidates for the group's purpose	-	2	-	-	2
Group Leader/Therapist	GT-GLT	Therapist trained in individual and group therapy, responsible for determining group size, gender, type of client, and open or closed group	1	1	-	1	2
Group Purpose	GT-GP	Group's specific reason for meeting, and group goals and objectives. Members meet only during sessions	3	1	1	1	2
Confidentiality	GT-CN	Rule that group members' statements are not to be shared outside the confines of the session	2	1	-	1	1
Structure	GT-ST	Stages, boundaries, and rules for group attendance, participation, communication, etc.	4	2	-	4	17
Group/Individual Goals	GT-GIG	Identified goals to be achieved by individual clients and the group	1	1	-	-	2
Open/Closed Group	GT-OCG	Type of group: <i>Open group</i> maintains size by admitting new members as members leave; <i>closed group</i> admits no new members once the group has begun	5	-	-	1	1
Open/Honest Talk/Self-Disclosure	GT-OTSD	Personal sharing of perspectives or information that would not be shared in normal, daily social situations	1	8	3	4	3
Relationship Building	GT-RB	Establishment and maintenance of relationships that assist in managing behaviors	1	6	4	4	4
Social Support	GT-SS	Development of close bonds with others dealing with similar problems	3	11	5	6	7
Interpersonal Conflicts	GT-IC	Conflicts between group members	-	1	-	-	-
Examine Addictive Process	GT-EAP	Examination of group members' thoughts and feelings to help with issues and concerns	5	7	-	4	24
Initial/Beginning Stage	GT-BS	Stage in which group members introduce themselves and establish group norms, goals, and supervision by the therapist	1	-	-	-	-
Middle/Working Stage	GT-WS	Stage in which the group focuses on achieving its purpose and establishes cohesion, balance, trust, and cooperation; members gain comfort with self-disclosure; and the group	1	-	-	-	-

		benefits from members' participation					
Closing/Ending Stage	GT-ES	Stage in which the group's purpose has been accomplished, members' needs have been met, and the group terminates	3	-	-	-	-

Table 4.5

Mindfulness-Based Cognitive Therapy Key Components Used in FBTs

Components	Codes	Definitions	FBT-1	FBT-2	FBT-3	FBT-4	FBT-5
Focus on Present Moment, Awareness, and Acceptance	MBCT-FPMA	Emphasis on awareness of the present moment; external triggers; and patterns of emotional, cognitive, and behavioral reactions. Focus is on awareness of the process and nature of thought, not on challenging its content	3	-	-	3	-
Nonjudgmental	MBCT-NJ	No judgments made; void of moral values or beliefs	-	-	-	-	-
Non-Religious Meditation	MBCT-NRM	Contemporary psychological application of the clinical aspects of mindfulness practices in a secular context	-	-	-	-	-
Expect/Tolerate Problematic Experiences	MBCT-ETPE	By observing sexually-related thought, clients examine cognitive processes related to triggers, urges, and cravings and reframe problematic experiences to become expected and tolerable	-	-	-	-	-
Reflect, Do Not React	MBCT-RDNR	Client learns to stay with the discomfort and pause before engaging in reactive behavior, regardless of the situation/content, then let go of the thought and return to observing passing thought(s)	-	-	-	-	-
Stress Reduction	MBCT-SR	Client learns to identify the underlying urge or craving to meet the need more skillfully and effectively. Practices are “intended to liberate the practitioner and allow him or her to shift away from cognitive and behavioral patterns that lead to suffering . . . craving is a natural phenomenon that must be understood and accepted” (p. 514).	1	-	-	-	-
Breathing Exercises	MBCT-BE	SOBER —Stop Observe Breathe Expand Respond—is a practice that focuses on breathing and fosters awareness of rumination, automatic thinking, emotions, and sensations, prompting a shift to more nonjudgmental, present-focused thinking	1	-	-	-	-

Coping Skills/Exercise Homework	MBCT-CSEH	Practices that “target tolerance of negative physical, emotional, and cognitive states, thereby decreasing the need to alleviate discomfort by engaging in impulsive behavior.” (p. 515)	4	-	-	-	-
Relapse Prevention	MBCT-RP	“Intervention applied with an individual in the recovery and maintenance phase of addiction that focuses on skill building to prevent the reoccurrence of the addictive behavior.” (p. 521)	1	-	-	-	-

Research Questions Answered

This study sought to answer two research questions:

1. Are faith-based organizations designing curricula for treating problematic pornography use, sexual problems, and sexual addiction that include the key components of EBTs?
2. To what degree are themes in faith-based ministry curricula for problematic sexual behaviors focused on non-addictive approaches? More specifically, do the current curricula differentiate between addictive and problematic sexual behavior?

FBT-1

The QICA results show that FBT-1 contains key components of CBT, BPT, MI, GT, and MBCT. However, most of the key components included in FBT-1 are from CBT, BPT, and GT, but few from MI and MBCT. The number of each EBT contained are CBT = 11, BPT = 8, MI = 5, GT = 13, and MBCT = 5.

In response to the second question, FBT-1 uses assessment tools to differentiate between sexual problems and sexual addiction. The manual advises, “For women presenting with concerns related to love and sexuality, regardless of the form this activity takes, (relational, solo, or a combination of the two), a comprehensive and holistic evaluation is the first step in

identifying the problem and developing an appropriate treatment plan” (Ferree, 2012, p. 67). The first three chapters of the FBT-1 manual are devoted to explaining, assessing, and diagnosing sexual addiction. However, the focus of FBT-1’s intensive workshop program is sexual addiction. The manual did not address treatment for non-addictive sexual behaviors.

FBT-2

The QICA results show that FBT-2 contains key components from CBT, BPT, and GT, but no components from MI or MBCT. The number of each EBT contained are CBT = 9, BPT = 6, MI = 0, GT = 11, and MBCT = 0.

In response to the second question, FBT-2 makes a distinction between those who desire to avoid developing sexual problems, those who are currently experiencing problematic sexual behaviors, and those who are sexually addicted. FBT-2 encourages those who are experiencing sexual problems to be properly assessed. “Once someone has agreed to get treatment for sexual addiction, the first step is to find someone who can determine whether he or she really is a sex addict. There are a growing number of counselors who are trained to do this. They will ask for a history of behaviors and feelings and give their opinion about the direction treatment should take” (Laaser, 1992, p. 146).

FBT-3

The QICA results show that FBT-3 contains some of the key components of CBT and GT, but few or none from BPT, MI, or MBCT. The number of each EBT contained are CBT = 5, BPT = 2, MI = 0, GT = 4, and MBCT = 0.

In response to the second question, FBT-3 makes no distinction between sexual problems and sexual addiction. On the first page of Chapter One, the manual says, “The fallout from our

sex-charged society is that sex addiction has become commonplace” (Hesch, 2016, p. 7). The author goes on to discuss all the sexual problems of men in the church.

FBT-4

The QICA results show that FBT-4 contains many of the key components from CBT and GT, three from BPT, none from MI, and three from MBCT. The number of each EBT contained are CBT = 8, BPT = 3, MI = 0, GT = 8, and MBCT = 1.

In response to the second question, FBT-4 assesses the severity of sexual addiction, which is its focus. It makes no distinction between sexual problems and sexual addiction and uses one approach for all men. The manual says, “Sexual addictions are not just about sex, but about how we process the hurts, hassles, and hopes of our lives” (Roberts, 1999, p. 26).

FBT-5

The QICA results show that FBT-5 contains many of the key components from CBT, BPT, and GT, but no key components from MI or MBCT. The number of each EBT contained are CBT = 5, BPT = 3, MI = 0, GT = 12, and MBCT = 0.

In response to the second question, FBT-5 makes no distinction between sexual problems and sexual addiction. The beginning of the manual says, “This book is for those who want to stop their sexually self-destructive thinking and behavior” (Sexaholics Anonymous, 1989, p. ix).

Evidence of Quality

As noted above, the coding frame for data analysis was developed based on the key components identified in the EBT manuals (see Tables 3.1-3.5). These codes were matched to terms, phrases, and explanations used in each FBT manual to determine whether EBT key components were included in the curricula. The coding system was built, tested, then modified to

collapse or combine any overlapping codes. The study's methodology followed Schreier's (2014) QICA procedure. (See Appendices A-E for the coding frame and all FBT quotes.)

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

IP use, sexual problems, and reported sexual addictions are on the rise globally and have been cited as some of the most serious issues facing religious communities today (Giordano & Cecil, 2014; Giordano et al., 2017; Grubbs, Exline, et al., 2015; Grubbs et al., 2010; Perry & Hayward, 2017; Perry & Whitehead, 2018). Although sexual addiction is not included in the *DSM-5* as an official diagnosis, a wide range of interventions has been developed to address sexual addiction and other sexually related issues. Faith-based organizations have responded to reports of sex-based issues in religious communities by developing curricula that integrate faith-based components.

However, ministries may be ill suited to develop treatment approaches that are empirically supported when faith integration and worldview have philosophical pre-eminence (Ferree, 2002; Thomas, 2016; Volk et al., 2017). Further, there is significant evidence that religious populations tend to overpathologize their sexual behaviors when it conflicts with their religious beliefs (Grubbs et al., 2010; Grubbs, Volk, et al., 2015; Thomas, 2016; Wilt et al., 2016). The rising number of sexually-related problems reported in the church combined with the overpathologizing of those behaviors makes it essential to ensure that faith-based curricula employed in religious settings have the necessary components to treat sexual psychopathology effectively and to distinguish between those with and those without psychopathology (Giordano & Cecil, 2014; Reid et al., 2016; Thomas, 2016). The purpose of this study was to examine the curricula of five FBT programs for treating sexual addiction and other sexually related issues and assess whether these FBTs integrated key components of EBTs. Presumably, the degree to which

EBT approaches are implemented within FBT frameworks will predict the FBTs' success in treating clients with sexually related problems.

Limitations

This was not an exhaustive study of the curricula of the five FBTs, as some sections of those curricula were beyond the scope of the current research. Because this study focused on EBTs as they applied to individual therapy, these EBTs did not contain components of family therapy, couples therapy, or religiosity/spirituality. Thus, the FBT sections that dealt with family therapy, couples therapy, and religiosity/spirituality were excluded from the study.

The results of this qualitative study were based on the written information contained in the FBT treatment manuals. The FBT programs selected were the only FBT programs found that made their sexual addiction treatment materials available for use by churches. The FBT manuals documented the procedures involved in each approach, and the components of those procedures were compared with the key EBT components identified in the coding frame. However, there was no way to verify that the procedures documented in the FBT manuals were actually implemented in practice.

Summary of Findings

Using a qualitative inductive content analysis methodology, five faith-based interventions for sex addiction and other self-reported sexual problems were assessed for components of empirically based treatments. A coding frame was constructed based on the manuals from five empirically based treatments, including a) cognitive behavioral therapy (Cully & Teten, 2008), b) brief psychodynamic therapy (Center for Substance Abuse Treatment, 1999; Substance Abuse

and Mental Health Services Administration, n.d.), c) motivational interviewing (DiClemente, 2006; Miller & Rollnick, 2013), d) group therapy (Brabender et al., 2004; Yalom & Leszez, 2005), and e) mindfulness-based cognitive therapy (Witkiewitz et al., 2014). The manuals describing the faith-based interventions were examined for consistency with the five empirically supported treatments for sexual addiction.

Over 900 passages that were consistent with empirically supported treatment approaches were identified across the five faith-based curricula. The following components were found within each FBT:

- *FBT-1* contained the most EBT key components, including 11 of the 12 CBT components, eight of the eight BPT components, five of the 17 MI components, 13 of the 15 GT components, and five of the nine MBCT components.
- *FBT-2* contained the second highest number of EBT components, including nine of the 12 CBT components, six of the eight BPT components, none of the 17 MI components, 11 of the 15 GT components, and none of the nine MBCT components.
- *FBT-3* contained the fifth highest number of EBT components, including five of the 12 CBT components, two of the eight BPT components, none of the 17 MI components, four of the 15 GT components, and one of the nine MBCT components.
- *FBT-4* contained the fourth highest number of EBT components, including eight of the 12 CBT components, three of the eight BPT components, none of the 17 MI components, eight of the 15 GT components, and one of the nine MBCT components.
- *FBT-5* contained the third highest number of EBT components, including five of the 12 CBT components, four of the eight BPT components, none of the 17 MI components, 12 of the 15 GT components, and none of the nine MBCT components.

All the faith-based materials integrated some components of empirically supported treatments into their approaches. CBT, BPT, and GT are the EBTs whose components are most frequently represented in these FBT curricula; these are also the EBTs that have been found most effective in treating sexual addiction (Acharjee et al., 2014; Derbyshire & Grant, 2015; Garcia & Thibaut, 2010; Rosenberg et al., 2014). Four of the five FBTs contained no MI components and three of the five FBTs contained no MBCT components in the FBT curricula.

Three of the five FBTs conduct assessments in their programs, but only FBT-2 offers two treatment approaches to help both the sexually addicted and the sexually *non-addicted*. The FBT-2 manual explains, “The first approach to this workbook is for those who struggle in a more serious way with issues of sexuality. . . . Your first task will be to find sobriety—to stop the specific sinful sexual actions—and to gain peace from the slavery of powerful sexual thoughts and behaviors” (Laaser, 1996, p. 6). It adds, “The second approach is for those who are not struggling with sinful sexual behaviors, but who want to guard themselves against them in our progressively sexual culture” (Laaser, 1996, p. 6). FBT-2 differentiates between the two approaches by recognizing that some men may need help with sexual struggles although they are not sexually addicted. None of the other FBTs distinguish between those with sexual addiction and those with non-addictive sexual struggles. Although both FBT-1 and FBT-4 employ assessments that could be used to distinguish those who are addicted from those who are not, neither provides specific treatment for non-addictive sexual problems.

Interpretation of Findings

All the faith-based treatments contain components of empirically supported treatments. Only one of the faith-based manuals effectively differentiated between those dealing with sexual

struggles and those confronting sexual addiction. These results suggest that individuals who struggle with sexually-related addictive patterns of thought or behavior are likely to find relief in these faith-based interventions. Given the lack of differentiation between addiction and non-addictive sexual struggles (i.e., dissonance between sexual behavior and beliefs), however, there is a high risk that religious communities will overapply these interventions and over-pathologize common sexual struggles.

Implications for Social Change

All five of these FBT programs use GT or 12-step programs, although FBT-1 and FBT-4 are the only two FBTs that recommend pursuing individual therapy along with GT. It is unclear whether individual psychotherapy is encouraged or made available in the other three FBT programs. Moreover, while group therapy and 12-step programs can help sex addicts build positive relationships, establish strong support systems, and learn from one another, these treatment approaches do not help individuals identify or change the dysfunctional core beliefs that can drive problematic sexual behaviors (Ferree, 2012).

Additionally, group therapy does not create a therapeutic alliance, which is a vital element of therapeutic success that uses relational factors to promote healing and personal growth (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Ferree, 2012; Magnavita, 2006; Romano, Fitzpatrick & Janzen, 2008). Ferree (2012) observes that “today the majority of clinical thought views the therapeutic alliance as a critical, crucial, and even the most important variable in treatment success, regardless of treatment modalities” (p. 95). Both individual and group therapies are effective and necessary to help individuals overcome sexual addiction. Churches therefore need to offer sexual addiction treatment programs that incorporate assessment,

diagnosis, and proper therapeutic approaches, as well as individual and group therapy conducted by trained Christian mental health professionals.

Although all the FBTs contain some EBT key components, they also contain some non-EBT key components. Three of the FBTs adhere only to a Christian worldview, incorporating a religious/spiritual component and employing a Biblical counseling approach. The Christian worldview is written in the beginning of each of the three FBTs as follows: “We are all sexual beings created in the image of God” (Laaser, 1996, p. 7); “Begin this morning by memorizing the weekly memory verse [Scripture]” (Hesch, 2016, p. 13); and “Restoration – Accepting life on God’s terms, with trust, grace, mercy, vulnerability, and gratitude” (Roberts, 2004, p. 14). FBT-5 says, “Made a decision to turn our will and our lives over to the care of God as we understand Him” (SA, 1989, p. 6). FBT-1 says on its website that it is a Christian treatment center that uses Christian principles in its treatment. It also says it begins therapy with Scripture reading. The manual uses an inclusive religious approach that is open to any religious belief. The manual says, “We recommend starting with a moment of silence to ask a Higher Power for guidance and to summon forth for the meeting the presence of the strong recovering woman inside” (Ferree, 2012, p. 129). These FBTs emphasize the need to include an individual’s faith as part of therapy (Ferree, 2012; Hesch, 2016; Laaser, 1996; Roberts, 1999; SA, 1989); they stress the importance of relationship building, and especially strengthening one’s relationship with God.

The FBTs also contain components that involve value systems, moral boundaries, and Biblical interpretations of right and wrong. While these components are helpful and convey Christian beliefs and values, the literature also shows that these components can produce guilt and shame when sexual behaviors violate these moral belief systems (Clarkson & Kopaczewski, 2013; Grubbs, Exline, et al., 2015; Thomas, 2016). As part of their religious foundation, each

FBT stresses the need for accountability, building a support system, restitution, and reconciliation, as well as emphasizing core values that are central to the Christian worldview. Within the framework of these four FBTs, accountability is a key component in treating sexual addiction, and establishing a strong support system is necessary to overcome sexual addiction.

The biological aspect of addiction is another component present in some FBTs but not found in the EBTs. FBT-1, FBT-2, and FBT-4 all use psychoeducation to thoroughly explain the biological foundations of sexual addiction (Ferree, 2012; Laaser, 1996; Roberts, 1999). They teach clients about the addiction process and how individuals get caught in the addiction cycle. While it is valuable to understand the addiction cycle, caution should be used so that moral issues and sin problems are not mistaken for sexual addiction, especially in those who are not sexually addicted (Thomas, 2016).

Further, all the FBTs stress the role of attachment problems, dysfunctional family relationships, forgiveness, self-forgiveness, restoration of relationships, and reconciliation of broken family relationships in the treatment of sexual addiction. These components are key aspects of therapy undertaken from a Christian worldview. However, these components may be most applicable to those suffering from the “classic” form of sexual addiction, which many characterize as an intimacy disorder (Schwartz & Southern, 2017). The non-EBT components contained in the FBTs may be therapeutically applicable to and useful for those who have experienced trauma in relationships at early ages.

In contrast, these components may not apply to those suffering from the “contemporary” form of sexual addiction, which results from continuous access to the Internet and the “3Cs”—chronicity, content, and culture. These individuals may have no history of abuse, trauma, or early attachment problems (Riemersma & Sytsma, 2013), and the fast-changing cultural and sexual

norms move them more quickly toward virtual and non-relational sexual addictions (Giordano et al., 2017). This type of sexual addiction appears to affect equally all ages, genders, cultures, ethnicities, socioeconomic levels, and educational levels that have access to the Internet (Riemersma & Sytsma, 2013). Thus, the current FBT approach for dealing with sexual addiction, which targets dysfunctional core beliefs from early childhood trauma, may not be effective for this “contemporary” form of sexual addiction (Riemersma & Sytsma, 2013).

Recommendations for Action

This study investigated two key research questions regarding the treatment of sexual problems and sexual addiction in the church. In response to the first research question, the study found that the FBTs that are successful in treating sexual addiction *do* incorporate EBT components, which likely contribute to their effectiveness. In response to the second research question, only one of the five FBTs in this study provides a treatment approach for those with non-addictive sexual problems as well as an approach for treating sexual addiction. This is an important finding in that it appears that the overall approach to treating sexual problems within the religious community, and more specifically in four of these five FBTs, is a “one size fits all” treatment.

These findings raise questions about what happens when assessment scores indicate that an individual suffers from problematic sexual behaviors but *not* from sexual addiction. Four of the five FBTs give no indication of how they treat individuals who do not meet the criteria for sexual addiction yet want help in overcoming their sexual problems. If the FBTs’ approach to treating sexual addiction is, in fact, “one size fits all” and everyone seeking help receives the same treatment, then those who *perceive* themselves to be sexually addicted but do not meet the

sexual addiction criteria are either being defined and treated as sexually addicted individuals or are not receiving treatment at all.

If sexually non-addicted individuals are treated as though they present with sexually addictive symptoms, then their problems may likely develop into clinical problems. Such an approach violates the “do no harm” ethic of the mental health field, as individuals may be harmed by receiving the wrong type of treatment for sexual problems. However, if in practice sexually non-addicted individuals are treated with different approaches than those who are sexually addicted, the FBTs need to include that information in their manuals and outline these alternative treatments. Likewise, it would be helpful for them to outline how they treat sexual problems that result from moral or sin issues.

Because the current FBT approach for dealing with sexual addiction aims at dealing with dysfunctional core beliefs from early childhood trauma, this approach may be ineffective for this “contemporary” form of sexual addiction. This suggests that the religious community may be unprepared to treat individuals with sexual problems who are non-addicted, as well as individuals with the “contemporary” type of sexual addiction. The church and religious community must develop treatment approaches that can therapeutically assist all three types of individuals: those who are sexually addicted, those who struggle with sexual problems but are non-addicted, and those presenting with the “contemporary” form of sexual addiction.

These findings highlight several ways the FBTs can increase the effectiveness of their treatment approaches. First, FBTs need to expand their curricula to incorporate more of the EBT components proven effective in treating sexual addiction. Individuals seeking help from the church should be able to receive proper treatment that will “do no harm” while helping them overcome sexual addiction. Second, FBTs must recognize that “one size” does *not* fit all in

sexual addiction treatment, as not every individual seeking help for sexual problems is sexually addicted. However, these individuals may be struggling with moral/sin issues, which may need to be addressed with a non-therapeutic approach. Thus, FBTs should develop curricula that include approaches that differentiate between sexual addiction, non-sexual addiction, and moral/sin issues.

Recommendations for Further Study

Clinical studies are needed to determine the effectiveness of the non-EBT components found in these FBTs. It is well established that EBTs are effective in treating sexual addiction, yet it is unclear which, if any, of the non-EBT components used in these FBTs are effective in treating sexual addiction. The current study found no statistics in the manuals to convey the success of sexual addiction treatment in these FBT programs, nor was there any information on the relapse rates of those treated in these programs. Future studies are needed to establish success rates as well as relapse rates for these FBTs. Additionally, future studies are needed to determine whether FBT programs for sexual addiction that were not examined in this study also contain key EBT components, whether they intend to include them or not.

Four of the five FBTs heavily emphasize the inclusion of personal religious beliefs as a part of therapy. Adding a religious/spiritual component to the therapeutic process has received increased attention in the mental health field and has been shown to have a positive impact on the therapeutic outcome (Koenig, 2012). More research is needed to identify the benefits of including a religiosity/spirituality component in sexual addiction treatment. Lastly, the accountability component provides another area for further study, which should explore whether

its benefits derive primarily from the willingness to be accountable to another individual or from establishing a relationship and connection with another person.

Reflections on the Researcher's Experience

In approaching this study, I expected to find few if any key EBT components in these FBT programs. It was therefore a pleasant surprise to discover that the FBTs not only contained key EBT components but included many key components from the three main EBTs for sexual addiction—whether the FBTs were aware of using EBT components or not. As an LPC who is active in the ministry, I found this study to be a learning experience that provided valuable information for improving ministry within the church. The study's findings highlight the need for the religious community to improve its approaches to treating sexual addiction to effectively serve the needs of those seeking help from the church. Additionally, the study supports the need for Christian professionals with specialized clinical training to work in the church, employing the Biblical principles of Christian ministry.

Conclusion

The findings of this study show that key EBT components are included in the FBT curricula, which most likely contribute to the success of the FBT programs. Additionally, the FBT programs considered to be the most successful contained the most key EBT components. Thus, it appears that the presence of key EBT components in these FBT programs does make a difference.

Because research has shown that EBTs are effective in treating sexual addictions, it is vital for the church and religious community to recognize the need to include EBTs in sexual

addiction treatment. As the prevalence of sexual addiction and other sexual problems continues to increase due to easy access to the Internet and pornography, the need increases for proper treatments to be made available for use in the church. Additionally, there is an urgent need for Christian mental health professionals to be willing to work within the church, as many individuals who struggle with sexual addiction or other sexual problems will never seek treatment from secular mental health facilities.

The FBT curricula examined in this study have the potential to meet an identified need in the church for sexual addiction treatment. These FBTs therefore need to expand their programs to include a component for the non-addicted individual with sexual problems, and to incorporate proper treatment approaches for individuals who present with “contemporary” sexual addiction. With these added components, these programs can make a significant difference in helping church members overcome sexual addiction and other sexual problems, and in doing so positively influence the spiritual climate in the church.

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APPENDIX A: FBT Quotes of CBT Key Components

EBT-1: Cognitive Behavioral Therapy

<i>Faith-Based Treatment</i>	<i>Codes</i>	<i>Examples</i>	<i>Frequency Count</i>
FBT-1	CBT-IT	"Most clients will need considerable individual therapy before they're ready for a group" (p. 122). "Even if an FSLA participates in other treatment settings, individual psychotherapy forms the core of most women's healing work" (p. 109).	4
FBT-1	CBT-TA	"Developing rapport is more important initially than focusing on specific areas of sexual and love relationship behavior, including sexual history, current behaviors, and consequences of the behaviors" (p. 68). "If we correctly view sex and love addiction as a problem of disordered regulation due to a fundamental attachment disorder, the importance of the therapeutic relationship becomes even more clear" (p. 96).	12
FBT-1	CBT-PED	"Naming this addiction, which is critical for recovery, is a fragile process in the treatment of women" (p. 29). "Information giving. Psycho-education provides factual information regarding sex and love addiction, its etiology, progression, and effective methods for addressing it. Resources for FSLA are still scarce, and many women find the material written for men only increases their sense of being different" (p. 121).	7
FBT-1	CBT-ASM	"Timely, appropriate, and thorough assessment is the heart of effective treatment whether the presenting problem is physical, psychological, spiritual, or some combination of the above" (p. 67). "Assessment and diagnosing is essential to this process. Assessment requires questioning in areas of psychological, physical, environmental, social, and spiritual wellbeing" (p. 67).	10
FBT-1	CBT-CGTP	"Information gleaned from the various diagnostic tools can answer important questions that influence treatment planning" (p. 87). "The clinician will need to assess the FSLA's ability to participate in creating the treatment plan. The client needs to always be part of this process no matter how impaired she may be in the beginning of her healing" (p. 87).	2
FBT-1	CBT-ITH	"When used supportively at the right time, the recovery tasks can be helpful for FSLAs" (p. 97). "These task assignments are best used as opportunities to bond and connect. Be sure to incorporate your understanding of the female brain, her need for attachment, and her sensitivity to shame. Be with her in the process" (p. 97).	3

FBT-1	CBT-DCBT	"First and foremost the cycle begins with core beliefs that sex addicts hold about themselves (Carnes, 1991). "These beliefs set up individuals to hold negative views about themselves" (p. 34).	11
FBT-1	CBT-CDCBT	"It's also important to challenge her denial regarding the level of awareness she possessed in her attempts to control her acting out and avoid surrender" (p. 167). "Don't let her deny responsibility and accountability for these choices" (p. 168).	2
FBT-1	CBT-BA	"A task [Carnes' Task Model] represents an action step, which is positive and important, but for women is best done in connection with you, her therapist" (p. 97).	1
FBT-1	CBT-PS	"If a trauma response does occur, explore with her positive coping skills and other preventive measures that will help avert dysregulated emotions that may threaten to overwhelm her" (p. 68).	1
FBT-1	CBT-RLX		0
FBT-1	CBT-ETRP	"A graduation ceremony is a powerful and affirming way to mark the end of a woman's participation in group therapy, and it offers a chance for members to use their sensuality and creativity to fashion a meaningful send-off" (p. 151). "It's helpful to teach the FSLA practical ways to prepare in times of strength for the future times of weakness. She can create a list of anniversaries, holidays, and birthdays that are emotionally charged, which identifies potential high-risk times she's likely to reach out to a former partner" (p. 169).	11
FBT-2	CBT-IT	"To deal with unhealthy shame, sexual addicts must delve into their family background. While both individual and group therapy can be effective ways of exploring past abuse, I strongly recommend group therapy as opposed to or in addition to individual counseling...Many addicts learn about their own abuse by seeing other addicts deal with theirs" (p. 155-bk). "Sometimes going to meetings will be combined with counseling. Counseling in itself is usually inadequate; I know only one or two sex addicts who have achieved abstinence through counseling alone" (p. 147-bk).	3
FBT-2	CBT-TA		0
FBT-2	CBT-PED	"Sexual addiction is a sickness involving any type of uncontrollable sexual activity. Because the addict can't control his or her sexual behavior, negative consequences eventually result" (p. 21-bk). "The alcoholic will build tolerance of alcohol and therefore need more and more alcohol to achieve the same mood-altering effect. A sex addict is no different, needing to act out more and more frequently to obtain the same high" (p. 44-bk).	4

FBT-2	CBT-ASM	"Written diagnostic tests are also available...The oldest and most widely validated are instruments that Patrick Carnes has designed, the Sexual Addiction Screening Test (SAST) and the Sexual Addiction Inventory (SAI)" (p. 146-bk). "You may desire to get a professional evaluation before you begin the group process" (p. 9-wbk).	4
FBT-2	CBT-CGTP		0
FBT-2	CBT-ITH	"Once a diagnosis of sexual addiction has been made, five basic components of treatment based on the sexual addiction cycle are vital to recovery from sexual addiction: stopping the sexual behaviors, stopping the rituals, stopping the fantasizing, healing the despair, and healing from shame" (p. 146-bk). "I feel it is vitally important for sex addicts to stop all sexual behaviors for at least ninety days. They should agree to a total abstinence or 'celibacy' contract, which states that they will not be sexual with themselves (through masturbation) or anyone else. This contract reverses a sex addict's core belief and shows him or her that 'Sex is not my most important need'" (p. 147-bk).	10
FBT-2	CBT-DCBT	"Sex addicts...have a poor self-image. They perceive themselves as bad, evil people. Those around them may not know this, however, because such people may at times act as if they think highly of themselves" (p. 37-bk). "The negative self-image of the sex addict leads to chronic depression. The vast majority...have thought of suicide" (p. 38-bk).	31
FBT-2	CBT-CDCBT	"In recovery, addicts must be taught that they have choices about dealing with feelings. " (p. 154-bk). "When they are tired and lonely and begin to fantasize, they should ask themselves, 'What does this fantasy mean? What am I feeling? Am I sad, lonely, afraid, or what?' They can call someone to talk to. They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk).	7
FBT-2	CBT-BA	"They can call someone to talk to. They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk). "Say aloud the following affirmation three times: 'I am worthy of support and have the courage to get it'" (p. 17-wbk).	14
FBT-2	CBT-PS	"The following issues need to be dealt with in the recovery process: Understanding abuse, healing relationships, codependency, slips and relapse, and deepening spirituality " (p. 157-bk). "As you look at your ritual you will need to start thinking about prohibitions, sometimes called boundaries that you will enforce on yourself so that you can stop the ritual" (p. 55-wbk).	7

FBT-2	CBT-R		0
FBT-2	CBT-ETRP	"Sexual addicts will always need to go to meetings, get counseling, have a sponsor, and maintain their spiritual discipline. When they do these things they will continue to grow in all areas of their lives" (p. 156-bk). "The major question in recovery is whether a sexual addict can be completely healed. In recovery, a slip is when a sexual addict acts out once, while a relapse is a series of acting-out behaviors" (p. 160-bk).	10
FBT-3	CBT-IT		0
FBT-3	CBT-TA		0
FBT-3	CBT-PED	"Sexual fantasies are fabricated scenarios intended to serve you, please you, and give you what you think you deserve" (p. 11). "Any pattern of lust is very destructive" (p. 13).	4
FBT-3	CBT-ASM		0
FBT-3	CBT-CGTP		0
FBT-3	CBT-ITH		0
FBT-3	CBT-DCBT	"'You're so stupid. I don't think you have the brains you were born with!' These were harsh words. It was especially devastating because they came from his father, a man he looked up to" (p. 21). "Harsh words and disappointments were the norm in Tim's life. His father made a point of telling him, 'You're no good. You'll never amount to anything'" (p. 21).	31
FBT-3	CBT-CDCBT	"No longer say that you hate sexual sin, while secretly enjoying it. Turn away from false intimacy and be willing to accept the pain that goes along with real relationships" (p. 67). "It's time to reject performance-based thinking and self-condemnation" (p. 69).	8
FBT-3	CBT-BA	"Part of the process is allowing yourself to have and experience feelings, rather than stuffing them away. Yet, don't let feelings become your master. You need not give in to anger, greed, or lust" (p. 68). "Part of the process is allowing yourself to have and experience feelings, rather than stuffing them away. Yet, don't let feelings become your master. You need not give in to anger, greed, or lust" (p. 68).	24
FBT-3	CBT-PS	"...it's time for you to be open and honest with yourself...As you do, the need to escape into a fantasy world will shrink" (p. 68). "You need a separate game plan for each type of situation where temptation has seized you in the past" (p. 109).	10
FBT-3	CBT-R		0
FBT-3	CBT-ETRP		0
FBT-4	CBT-IT	"Counseling is important" (p. 88-bk).	1
FBT-4	CBT-TA		0

FBT-4	CBT-PED	"The key to sexual fulfillment is not found in our glands but in our heads. Therefore, the roots of sexual bondage are found in the way we think" (p. 31-bk). "A major aspect of sexual activity is a strong release of adrenaline and endorphins, which is why sexual events become imprinted in the brain. These events are memorable because we rehearse them again and again in our minds, even affecting our very perceptions of life and how we deal with the present. This is the second reason why the battle over sexual issues can be so severe for some people" (p. 32-bk).	26
FBT-4	CBT-ASM	"But when it comes to sexual bondage, the same factor is so high and the denial so deep...that it's difficult to break through. That's one of the reasons I've found Dr. Carnes's Sexual Addiction Screening Test [SAST]...such an important tool in helping men break out of denial" (p. 116-bk). "Dr. Carnes's SAST analysis consists of 25 simple questions...I've found that most men honestly want to know where they are in this battle, because nearly every man, at some point, has struggled with this issue" (p. 117-bk).	3
FBT-4	CBT-CGTP		0
FBT-4	CBT-ITH	"In order to truly renew your mind, plan to do homework 30 minutes each day, rather than doing it all at one sitting or at the last minute before group" (p. 13-wbk).	1
FBT-4	CBT-DCBT	"My family of origin had given me a good dose of dysfunctional software. Vietnam gave me a huge load of trauma and reinforced my survivor mentality" (p. 65-bk). "It's the war that comes from painful interpersonal relationships, especially when families are sick. Dysfunctional families don't just give us defective software for dealing with life; they can traumatize and scar our souls" (p. 65-bk).	47
FBT-4	CBT-CDCBT		0
FBT-4	CBT-BA	"Addicts need to do two things: First, they need to develop a series of action steps that can serve as an escape route when they find themselves moving into a high-risk time" (p. 123-bk). "When you are dealing with addictive behaviors, there is no such thing as standing still or maintaining the status quo. You are either working towards restoration or falling back into addiction. Failing to plan your next move forward is planning for relapse" (p. 10-bk).	4
FBT-4	CBT-PS	"That's why it's absolutely necessary for him to identify the specific things that set him up—the triggers and addictive rituals he's developed to make him feel better when he's down" (p.121-bk). "We must know ahead of time what to do in any given situation" (p. 122-bk).	7
FBT-4	CBT-R		0

FBT-4	CBT-ETRP	" <i>Relapse</i> is the third and main reason people remain in sexual bondage" (p. 110-bk). "We have to think through what we'll do if we relapse into our old behavior. A plan doesn't give us permission to relapse, but it does help us to know how we can turn a slip into a future victory" (p. 125-bk).	7
FBT-5	CBT-IT		0
FBT-5	CBT-TA		0
FBT-5	CBT-PED	"The specialized nature of Sexaholics Anonymous can best be understood in terms of what we call the sexaholic. The sexaholic has taken himself or herself out of the whole context of what is right or wrong. He or she has lost control, no longer has the power of choice, and is not free to stop. Lust has become an addiction" (p. 3). "Our experiences have revealed three aspects of our condition that commonly identify addictions: tolerance, abstinence, and withdrawal" (p. 30).	10
FBT-5	CBT-ASM		0
FBT-5	CBT-CGTP		0
FBT-5	CBT-ITH	"I also abstained from all sex, including with my wife" (p.21). "But one day at a time, one encounter at a time, one glance at a time, one thought or memory at a time. I don't have to act on those impulses. I don't have to drink it in" (p. 24).	2
FBT-5	CBT-DCBT	"When I told mother about my first masturbation, she told me not to touch myself and to never bring it up again. Of course, she didn't handle the situation right, but that's where I seem to connect with the wrong in me. I closed off inside, like dropping a curtain between me and her--and the world too, somehow. I threw some kind of tremendous silent switch. I would never again be on the outside what I was on the inside. What I was on the inside suddenly changed, and part of me retreated into that dark tunnel, way inside myself. I think that's when my resentment must have crystalized inside me. I remember turning away from my mother, silently submissive on the outside, but something on the inside turned deep and dark" (p. 47). "Based on real or imagined injury, we create and hold on to a wrong toward another; we choose to distort the truth. Rebellion and hence resentment are born, (Perhaps a more inclusive term, sin, would be more appropriate)" (p. 48).	24
FBT-5	CBT-CDCBT	"The crucial change in attitude began when we admitted we were powerless, that our habit had us whipped. We came to meetings and withdrew from our habit. For some, this meant no sex with themselves or others, including not getting into relationships. For others it	2

also meant "drying out" and not having sex with the spouse for a time to recover from lust" (p. 61).

"We discovered that we could stop, that not feeding the hunger didn't kill us, that sex was indeed optional. There was hope for freedom, and we began to feel alive.

Encouraged to continue, we turned more and more away from our isolating obsession with sex and self and turned to God and others" (p. 61).

FBT-5	CBT-BA	"All this was scary. We couldn't see the path ahead, except that others had gone that way before. Each new step of surrender felt it would be off the edge into oblivion, but we took it. And instead of killing us, surrender was killing the obsession! We had stepped into the light, into a whole new way of life" (p.61).	1
FBT-5	CBT-PS	"As we faced our defects, we became willing to change; surrendering them broke the power they had over us. We began to be more comfortable with ourselves and others for the first time without our "drug" (p. 62). "Forgiving all who had injured us, and without injuring others, we tried to right our own wrongs. At each amends more of the dreadful load of guilt dropped from our shoulders, until we could lift our heads, look the world in the eye, and stand free" (p. 62).	4
FBT-5	CBT-R		0
FBT-5	CBT-ETRP		0

APPENDIX B: FBT Quotes of BPT Key Components

EBT-2: Brief Psychodynamic Therapy

<i>Faith-Based Treatment</i>	<i>Codes</i>	<i>Examples</i>	<i>Frequency Count</i>
FBT-1	BPT-IP	"Most clients will need considerable individual therapy before they're ready for a group" (p. 122). " Individual therapy initially focuses on helping the FSLA de-escalate the areas of unmanageability and crisis in her life" (p. 109).	3
FBT-1	BPT-TA	" Developing rapport is more important initially than focusing on specific areas of sexual and love relationship behavior, including sexual history, current behaviors, and consequences of the behaviors" (p. 68). "If we correctly view sex and love addiction as a problem of disordered regulation due to a fundamental attachment disorder, the importance of the therapeutic relationship becomes even more clear" (p. 96).	11
FBT-1	BPT-DFL	"Growing up separate and alone, FSLAs long to be held like children even as adults . In addictive relationships, clients struggle to have this craving satiated" (p. 54). "We saw that when a child suffers any type of trauma , her brain systems get twisted toward offensive or defensive purposes instead of their proper ones. Social synapses no longer seek exciting discoveries about the world, but focus on predicting when others will become dangerous" (p. 189).	2
FBT-1	BPT-MTG	"To treat FSLAs, it's certainly necessary to establish sexual sobriety quickly through cognitive-behavioral therapy and usually a Twelve Step program focused on sex and love addiction" (p. 189).	1
FBT-1	BPT-UCCB	"First and foremost the cycle begins with core beliefs that sex addicts hold about themselves (Carnes, 1991). These core beliefs are: (1) I am basically a bad, unworthy person; (2) No one would love me as I am; (3) No one will meet my needs; (4) Sex or an intense relationship is my most important need" (p. 34). "These beliefs set up individuals to hold negative views about themselves " (p. 34).	11
FBT-1	BPT-CI		0
FBT-1	BPT-DM	"What is the nature of her defenses and what is the best way to help her to utilize higher functioning defenses and relinquish primitive defenses (denial, minimization, projection)? " (p. 88).	1
FBT-1	BPT-T	"When working with individuals with attachment issues like FSLAs, transference inevitably occurs. This process is normal as the client unconsciously transfers earlier experiences, perceptions, feelings, and longings about a significant person onto her therapist" (p. 102). "As the therapeutic relationship deepens, the client begins to experience you the same way she experienced people	

and situations from her past. Therefore, you become the triggering mom of the FSLA's childhood, or the abusive former friend, or the abandoning lover or the absent father" (p. 102).

FBT-2	BPT-IP	"To deal with unhealthy shame, sexual addicts must delve into their family background. While both individual and group therapy can be effective ways of exploring past abuse, I strongly recommend group therapy as opposed to or in addition to individual counseling...Many addicts learn about their own abuse by seeing other addicts deal with theirs" (p. 155). "Sometimes going to meetings will be combined with counseling. Counseling in itself is usually inadequate; I know only one or two sex addicts who have achieved abstinence through counseling alone" (p. 147-bk).	3
FBT-2	BPT-TA		0
FBT-2	BPT-DFL	"In recovery, addicts must be taught that they have choices about dealing with feelings" (p. 154-bk). "When they are tired and lonely and begin to fantasize, they should ask themselves, 'What does this fantasy mean? What am I feeling? Am I sad, lonely, afraid, or what?' They can call someone to talk to. They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk).	2
FBT-2	BPT-MTG	"The first approach to this workbook is for those who struggle in a more serious way with issues of sexuality... Your first task will be to find sobriety—to stop the specific sinful sexual actions—and to gain peace from the slavery of powerful sexual thoughts and behaviors" (p. 6-wbk).	1
FBT-2	BPT-UCCB	"Sex addicts...have a poor self-image. They perceive themselves as bad, evil people. Those around them may not know this, however, because such people may at times act as if they think highly of themselves" (p. 37-bk). "The negative self-image of the sex addict leads to chronic depression. The vast majority...have thought of suicide" (p. 38-bk).	12
FBT-2	BPT-CI	"In recovery, addicts must be taught that they have choices about dealing with feelings. When they are tired and lonely and begin to fantasize, they should ask themselves, 'What does this fantasy mean? What am I feeling? Am I sad, lonely, afraid, or what?' They can call someone to talk to. They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk).	1
FBT-2	BPT-DM	"Many sex addicts deny they are addicted because they have been acting in or white knuckling for long periods of time. In this form of total self-denial they completely turn off their sexuality" (pp. 40-41-bk). "One of the tools of	9

denial is delusion, the belief that the addictive behavior is not really that bad or harmful" (p. 43-bk).

FBT-2	BPT-TR		0
FBT-3	BPT-IP		0
FBT-3	BPT-TA		0
FBT-3	BPT-DFL		0
FBT-3	BPT-MTG	"I see a nation...where every man claims his own sexual integrity and, when he is tested, he stands firm" (p. xi).	1
FBT-3	BPT-UCCB	"'You're so stupid. I don't think you have the brains you were born with!' These were harsh words. It was especially devastating because they came from his father, a man he looked up to" (p. 21). "Harsh words and disappointments were the norm in Tim's life. His father made a point of telling him, 'You're no good. You'll never amount to anything'" (p. 21).	49
FBT-3	BPT-CI		0
FBT-3	BPT-DM		0
FBT-3	BPT-T		0
FBT-4	BPT-IP		0
FBT-4	BPT-TA		0
FBT-4	BPT-DFL		0
FBT-4	BPT-MTG		0
FBT-4	BPT-UCCB	"To deal with the noose of addiction, we have to cut the rope. We have to deal with the entire problem. We have to understand that the problem isn't just about the person's behavior or addictive lifestyle. It is about his past, the way he thinks and defense mechanisms he has developed to keep from being exposed. Sexual addiction isn't ultimately about sex; it is about the way the person deals with life" (p. 49)-bk).	1
FBT-4	BPT-CI		0
FBT-4	BPT-DM	"In the initial counseling session, the man may suggest that it is a recent problem, but that is a manifestation of denial that has become part of the way he thinks...it is just the way he has learned to look at life" (p. 51-bk). "The four biggest parasites in our world today are denial, minimizing, rationalization and disassociation.	6
FBT-4	BPT-TR		0
FBT-5	BPT-IP		0
FBT-5	BPT-TA		0
FBT-5	BPT-DFL	"Twenty years old on the outside, I was an emotionally stunted child-adolescent on the inside" (p. 13). "I became as a child, teachable, having to reject my way of doing and thinking for a new way of life based on surrender of my will to God. Then I began working on my defects, as they were uncovered not only in the inventory of my past, but in the continuing pain of seeing myself	3

trying to relate to others...I also began clearing away the wreckage of my past and making amends whenever I was wrong" (p. 23).

FBT-5	BPT-MTG		0
FBT-5	BPT-UCCB	"This distortion of reality produces a false spiritual high-satisfaction, pleasure, and release from the conflict produced by our wrong. Rebellion and resentment fill a need (really a demand)" (p. 48). "We take nourishment from the resentment; it sustains us. It sustains the new reality, which is a lie. It hides our wrong; we don't have to face it and deal with it. Thus, resentment is used as a drug" (p. 48).	24
FBT-5	BPT-CI	"What insights I did get into my motivations only seemed to add to the curse, much as did my religious knowledge and belief. Knowledge was not power—even right knowledge! What I needed was not more knowledge about my psychology or God, but power to stop what I was powerless over and obey the little light I already had" (p. 18). "For me the key was finally giving up all expectations of either sex or affection, and working on myself and my defective relations with others" (p. 24).	3
FBT-5	BPT-DM	" At first, it's a pleasurable way to cope with your inner conflict or stress or pain that seems intolerable. It works" (p. 35). "The addictive patterns lower our level of consciousness and remove us from life's mainstream. We are driven to spend more time thinking about and carrying out our addiction. At the same time, we deny the addiction to avoid the pain of recognizing how much of our life it has invaded and controls" (p. 36).	10
FBT-5	BPT-T		0

APPENDIX C: FBT Quotes of MI Key Components

EBT-3: Motivational Interviewing

<i>Faith-Based Treatment</i>	<i>Codes</i>	<i>Examples</i>	<i>Frequency</i>
FBT-1	MI-TP		0
FBT-1	MI-AC		0
FBT-1	MI-C		0
FBT-1	MI-EV		0
FBT-1	MI-EN		0
FBT-1	MI-F		0
FBT-1	MI-EV		0
FBT-1	MI-P		0
FBT-1	MI-OEQ		0
FBT-1	MI-AF		0
FBT-1	MI-RL		0
FBT-1	MI-S		0
FBT-1	MI-PCS	"This point means that she'll likely use any excuse to leave group and say it's not right for her" (p. 145). "She isn't convinced that the negative aspects of her behavior outweigh the positive. These clients are either reluctant, rebellious, or resigned, and they can rationalize their way out of almost anything" (p. 145).	1
FBT-1	MI-CS	"This FSLA knows there's a serious need for change , but she goes back and forth between considering change and then rejecting it. Your role is to help tip the balance in favor of change" (p. 147).	1
FBT-1	MI-PPS	"The FSLAs in the determination [preparation] stage have made some small efforts to change, but they haven't fully embraced everything necessary to really change. These are group members who're excited to do assignments, but don't always follow through" (p. 147).	1
FBT-1	MI-AS	"In the action stage the FSLA is consistently engaging in particular actions intended to bring about the desired change...When someone is in the action stage, she often wants to look good to the others and doesn't ask for help when she really should" (p. 148).	1
FBT-1	MI-MS	"This final stage is when the FSLA is really working to identify high-risk situations and coming up with action plans for those troublesome areas" (p. 148).	1
FBT-2	MI-TP		0
FBT-2	MI-AC		0
FBT-2	MI-C		0
FBT-2	MI-EV		0
FBT-2	MI-EN		0
FBT-2	MI-F		0

FBT-2	MI-EV	0
FBT-2	MI-P	0
FBT-2	MI-OEQ	0
FBT-2	MI-AF	0
FBT-2	MI-RL	0
FBT-2	MI-S	0
FBT-2	MI-PCS	0
FBT-2	MI-CS	0
FBT-2	MI-PPS	0
FBT-2	MI-AS	0
FBT-2	MI-MS	0
FBT-3	MI-TP	0
FBT-3	MI-AC	0
FBT-3	MI-C	0
FBT-3	MI-EV	0
FBT-2	MI-EN	0
FBT-3	MI-F	0
FBT-3	MI-EV	0
FBT-3	MI-P	0
FBT-3	MI-OEQ	0
FBT-3	MI-AF	0
FBT-3	MI-RL	0
FBT-3	MI-S	0
FBT-3	MI-PCS	0
FBT-3	MI-CS	0
FBT-3	MI-PPS	0
FBT-3	MI-AS	0
FBT-3	MI-MS	0
FBT-4	MI-TP	0
FBT-4	MI-AC	0
FBT-4	MI-C	0
FBT-4	MI-EV	0
FBT-4	MI-EN	0
FBT-4	MI-F	0
FBT-4	MI-EV	0
FBT-4	MI-P	0
FBT-4	MI-OEQ	0
FBT-4	MI-AF	0
FBT-4	MI-RL	0
FBT-4	MI-S	0
FBT-4	MI-PCS	0
FBT-4	MI-CS	0
FBT-4	MI-PPS	0
FBT-4	MI-AS	0
FBT-4	MI-MS	0
FBT-5	MI-TP	0

FBT-5	MI-AC	0
FBT-5	MI-C	0
FBT-5	MI-EV	0
FBT-5	MI-EN	0
FBT-5	MI-F	0
FBT-5	MI-EV	0
FBT-5	MI-P	0
FBT-5	MI-OEQ	0
FBT-5	MI-AF	0
FBT-5	MI-RL	0
FBT-5	MI-S	0
FBT-5	MI-PCS	0
FBT-5	MI-CS	0
FBT-5	MI-PPS	0
FBT-5	MI-AS	0
FBT-5	MI-MS	0

APPENDIX D: FBT Quotes of GT Key Components

EBT-4: Group Therapy

<i>Faith-Based Treatment</i>	<i>Codes</i>	<i>Examples</i>	<i>Frequency</i>
FBT-1	GT-GM		0
FBT-1	GT-GLT	"Group therapy differs from Twelve Steps and other forms of support meetings in several important ways. The primary difference is that a licensed therapist(s) leads group therapy, and the safety of her clinical presence allows cross talk, discussion, and feedback, which enhance dialogue and intimacy among group members" (p. 119).	1
FBT-1	GT-GP	"If female sex and love addicts struggle with a fundamental attachment disorder, it's only logical that a key way to observe and address the manifestations of attachments injuries is through the crucible of a group setting" (p. 119). "A group with focused membership would be one that's only for female sex and love addicts (homogeneous)" (p. 125).	4
FBT-1	GT-C	"At a minimum the contract should include: Confidentiality regarding the anonymity of each person participating in group" (p. 126). " Confidentiality regarding the anonymity of each person participating in group" (p. 126).	2
FBT-1	GT-S	"A group is a set time that can't be changed based on a woman's unexpected schedule conflicts. If she misses her group session, the opportunity for that particular experience is lost. Depending on the contract for the group, the client may be charged for the session whether she's present or not" (p. 120). "Some groups for sex addicts require a certain amount of sobriety , usually somewhere between 30 to 90 days, and generally assume (or sometimes require) that the client is participating in a Twelve Step sex addiction fellowship" p. 125).	5
FBT-1	GT-GIG	"It's imperative to have a group contract regarding specific requirements and expectations for participation that each member signs and dates. Recovery is, in part, about making explicit commitments and keeping them . By making a contract in writing, there's no confusion about what's expected and what the boundaries are" (p. 125)	1
FBT-1	GT-OCG	"Almost all outpatient psychotherapy groups are closed , which means members can't join after the group starts (or at least after the first session or two)" (p. 124). "This policy [closed] maintains the safety of the group and is less threatening for many clients" (p. 124).	4

FBT-1	GT-OTSD	" Disclosure is one of the most difficult tasks for all addicts, and especially for women SLAs. It's very difficult for any FSLA to remain in recovery if she's holding onto a secret that is full of fear and shame. Disclosure to the therapist and/or a sponsor or group members is often the first step in being set free of the shame that binds the SLA to her pain. Disclosing to a partner or family is much more difficult" (p. 179).	1
FBT-1	GT-RB		0
FBT-1	GT-SS	"One of the benefits to recovery from sex and love addiction is that women who participate in Twelve Step programs can end up with life-ling friendships " (p. 293). "Participating in Twelve Step meetings creates opportunities to make friends of the same gender" (p. 294).	3
FBT-1	GT-IC		0
FBT-1	GT-EAP	" Naming this addiction , which is critical for recovery, is a fragile process in the treatment of women" (p. 29). "It's important to understand that there's a continuum to addictive behaviors . A woman may only look at pornography occasionally or infrequently become sexual with a partner more quickly than she intended. At times she may enjoy these behaviors, and at times she may regret them, but she doesn't feel despair about her actions and they don't cause disruptions to her life" (p. 31).	5
FBT-1	GT-BS	"We recommend starting with a moment of silence to ask a Higher Power for guidance and to summon forth for the meeting the presence of the strong recovering woman inside" (p. 129).	1
FBT-1	GT-WS	"After the check-in, a teaching segment usually follows in a psychoeducational group . Next, members are encouraged to share their reaction to the material, or their homework or assignment from the last session. Normally, every member has a chance to share" (p. 130).	1
FBT-1	GT-ES	"One of the most gratifying and important parts of group therapy is when a group member is genuinely ready to leave and is celebrated in her departure " (p. 131). "A conscious send-off is modeled in ways that are intimate, touching, and moving. For many women, this is the first time they've had the experience of leaving without some dramatic event that left both parties with hurt feelings and resentment" (p. 131).	3
FBT-2	GT-GM	"The first approach... is for those who struggle in a more serious way with issues of sexuality " (p. 6-wbk). "The second approach is for those who are not struggling with sinful sexual behaviors but who want to guard themselves against them in our progressively sexual culture" (p. 6-wbk).	2

FBT-2	GT-GLT	"Your group facilitator will help monitor these [group] rules. As the group becomes more comfortable with each other, members will be able to monitor themselves and each other" (p. 18-wbk).	1
FBT-2	GT-GP	"I am using the terminology that a support group is a gathering of people who wish to change something in their lives – such as a group of addicted persons committed together to overcome a specific behavior or a group of people who have suffered a loss gathered to work through their grief. Thus not everyone needs a support group, but everybody needs to be accountable" (p. 22-wbk).	1
FBT-2	GT-C	" Confidentiality is the cornerstone. We must agree that we will not share what we hear in group with anyone outside the group. As group members begin to trust each other, a sense of safety will grow" (p. 18-wbk).	1
FBT-2	GT-S	"Building intimacy and trust in a Faithful and True group depends on well-defined group rules " (p. 17-wbk). "We sometimes call these group rules boundaries . Boundaries are rules that create safety . A boundary is a way of defining conduct. It is an invisible barrier keeping out dangerous negative, and destructive behaviors and letting in healthy, positive, and constructive ones" (p. 17-wbk).	2
FBT-2	GT-GIG	"You will begin to develop a support system and set goals for your growth" (p. 11-wbk).	1
FBT-2	GT-OCG		0
FBT-2	GT-OTSD	"Once you start the group process you will want to share with the other group members any feelings that you have. You will be surprised to find that many of them have had the same feelings" (p. 9-wbk). "In our society, most people – especially men – have never experienced a group in which they can be totally honest and be held accountable with love" (p. 13-wbk).	7
FBT-2	GT-RB	"They can call someone to talk to . They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk). "To establish healthy relationships , the sex addict will have to establish healthy boundaries" (p. 159-bk).	6
FBT-2	GT-SS	"They can call someone to talk to . They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk). "In this unit I hope to lead you to identify your need for supportive and accountable relationships " (p.13-wbk).	11
FBT-2	GT-IC	"The safety rules also remind us that we may disagree with each other . We may not always like what other group members say or do . Being angry with others – including God – is not destructive...Rules 5, 6, 7, and 8 help us have constructive conflict" (p. 18-wbk).	1
FBT-2	GT-EAP	"The behaviors and characteristics of sexual addiction can be understood by what Dr. Carnes has described as the	6

Sexual Addiction Cycle. Sexual addicts, like all addicts, are ashamed and seek to escape this feeling through addictive activity; however, that behavior in turn increases the sense of shame. Escaping shame through addiction that in turn increases the shame is one cycle that a sexual addict experiences. This cycle needs to be understood in order to recover from sexual addiction" (p. 52- bk).

"The first part of the **sexual addiction cycle is preoccupation**. Rather than allowing themselves to experience their shame, pain, and loneliness, sex addicts will start thinking about sex. Preoccupation involves the building-block behavior of sexual fantasy" (p. 52).

FBT-2	GT-BS		0
FBT-2	GT-WS		0
FBT-2	GT-ES		0
FBT-3	GT-GM		0
FBT-3	GT-GLT		0
FBT-3	GT-GP	"...where every man claims his own sexual integrity and, when he is tested, he stands firm" (p. xi).	1
FBT-3	GT-C		0
FBT-3	GT-S		0
FBT-3	GT-GIG		0
FBT-3	GT-OCG		0
FBT-3	GT-OTSD	"...it's time for you to be open and honest with yourself...As you do, the need to escape into a fantasy world will shrink" (p. 68). "Push through the painful moments and become open and honest internally and externally" (p. 68).	3
FBT-3	GT-RB	"It's equally important for you to begin modeling openness with your relationships with others. You were created to experience intimacy with real people" (p. 68). "You were created for relationships" (p. 70).	4
FBT-3	GT-SS	"True networking (seeking out and engaging with others on a vulnerable level) provides a way of living out your real purposes" (p. 70). "Without a networking partner—someone who will encourage and even hold you accountable—your pride can return unchecked and lead to selfish, sexual sins" (p. 70).	5
FBT-3	GT-IC		0
FBT-3	GT-EAP		0
FBT-3	GT-BS		0
FBT-3	GT-WS		0
FBT-3	GT-ES		0
FBT-4	GT-GM		0
FBT-4	GT-GLT	"To help them effectively deal with the challenge of relapse, we have to be tough and tender at the same time.	1
FBT-4	GT-GP	"...for those who have tried to build sexual holiness in their lives and failed: (p. 12-bk).	1

FBT-4	GT-C	"Obviously, confidentiality and careful structuring of the group are essential" (p. 74-bk).	1
FBT-4	GT-S	"These group guidelines were designed to create a safe environment for open and honest conversation during group meetings. Read and discuss the following guidelines as a group, including when anyone new joins the group" (p. 22-wbk). "Covenant to Contend (CTC) -- the CTC is an open commitment of accountability which states why you have chosen to join a PD small group and what you are committed to do in order to win your battle with sexual addiction. At the bottom of the page you will notice a place for you and one other person to sign and date. This is a public commitment. Read the CTC and ask a member of your group to sign as a witness to your signature. Memo of Understanding. This document indicates that you have read and understand the purpose and parameters of PD groups and the moral and ethical obligations of leaders" (p. 22-wbk).	4
FBT-4	GT-GIG		0
FBT-4	GT-OCG	"Read and discuss the following guidelines as a group, including when anyone new joins the group" (p. 22-wbk).	1
FBT-4	GT-OTSD	"We need to be open about our weaknesses and struggles" (p. 58-bk). "If, however, we have an emergency procedure for relapse that calls us to honesty and accountability with our small group, we'll eventually be able to cut through the noose around our souls" (p. 125-bk).	4
FBT-4	GT-RB	"Practice the relational aspects of our action steps, such as calling a member of the small group. This is critical because, under pressure, we'll tend to draw back into our old patterns and not reach out" (p. 124-bk). "To be successful in avoiding relapse, you need mentors...these mentors must commit to teaching and guiding you, and you must commit to following them" (p. 147-bk).	4
FBT-4	GT-SS	"Small-group ministry is a critical key in this process" (p. 74-bk). "The weight of all of this [relapse]underlines the absolute necessity of developing effective small groups within the church to help men face this battle" (p. 110-bk).	6
FBT-4	GT-IC		0
FBT-4	GT-EAP	"First, Rob needs to become self-aware of the what, when, where, how, and why of his addiction. In other words, he needs to determine why he does the things he doesn't want to do. Most people who battle with addiction not only avoid exposing their secrets to others, but they also avoid looking at those feelings, thought, and beliefs that drive their addictive behavior" (p. 136-bk). "The Addictive Mindset: We can now begin to see the pattern with Rob. He is isolated and feeling anxiety and	4

fears that are creating emotional pain and despair in his life...he's emotionally distant from his wife and kids. He's drifting all alone in the midst of a family that loves him...He doesn't find much value in himself" (p. 139-bk).

FBT-4	GT-BS		0
FBT-4	GT-WS		0
FBT-4	GT-ES		0
FBT-5	GT-GM	"If there is no group where we live, we start one ourselves, even if it is meeting with only one other member...We contact the SA Central Office for any contacts there may be in our area and ask for materials and know-how...Long distances may separate members at first; some travel more than a hundred miles to meet with others" (p. 63). "Before inquirers attend their first meeting, one or more sober SA members talk with them on the phone or, preferably, meet with them...Telling them our story usually encourages them to tell their own, and once newcomers do this, they (and we) are better able to tell whether they identify and want recovery" (p. 180).	2
FBT-5	GT-GLT	"SA Tradition 8: "Sexaholics Anonymous should remain forever nonprofessional" (p. 7). SA Tradition 8: "Sexaholics Anonymous should remain forever nonprofessional" (p. 7).	2
FBT-5	GT-GP	"As we came to see that we shared a common problem, we last came to see that for us, there is a common solution—the Twelve Steps for recovery practiced in a fellowship and one foundation of what we call sexual sobriety" (p. 2). "The primary purpose of an SA group is "to carry the message to the sexaholic who still suffers (Tradition 5)" (p. 173).	2
FBT-5	GT-C	"Find a weekly meeting place and set the time. At first, this may be a private home or office, where anonymity and privacy can be assured" (pp. 173-174). "Precautions: We suggest that no ads of an kind be placed in newspapers, periodicals, on bulletin boards, et., even in other Twelve Step meetings, that disclose the where-about of SA meetings. Advertising time and place of meetings to the general public can cause problems. For the same reason we suggest that no signs be put up outside meeting places identifying as SA meetings" (p. 181).	2
FBT-5	GT-S	"Starting a Group: Find a weekly meeting place and set the time. At first, this may be a private home or office, where anonymity and privacy can be assured. Churches are often willing to provide facilities. Select a group secretary, treasurer, and literature chairperson. Advise the SA Central Office of the name and phone number of the secretary and an alternate contact and meeting particulars (pp. 173-174). "Commit yourself to your group...Attend every meeting on time. This ensures maximum benefit to	17

		you and the group, which cannot have continuity without regular participants" (p. 64).	
FBT-5	GT-GIG	"Everything begins with sobriety. Without sobriety, there is no program of recovery" (p. 77). "Step One, Two, and Three describe the change of heart from self to God, without which no real change in our lives can come about" (p. 80).	2
FBT-5	GT-OCG	"As a general principle, it is suggested that SA meetings be open only to those who want to stop their sexually self-destructive thinking and behavior. 'The only requirement for membership is a desire to stop lusting and become sexually sober' (Tradition Three)...Many may want a support group, but not sexual sobriety, and some may be more intent on changing SA than changing themselves, Keeping meetings 'closed' (open to sexaholics only) will help protect the membership from the curious and the insincere" (p. 176-177).	1
FBT-5	GT-OTSD	"What we are really saying when we start meeting with others is, 'I have to stop; please help me.' But we need some demonstration of trust, and hearing the stories of other members, we begin to let our guard down. Before we know it, we've crossed that line of doubt, mistrust, and fear, and have put down our drug" (p. 65). "Experience has shown us that the public aspect of surrender is crucial. It seems surrender is never complete until it is brought out into the open, into the company of others. This is the great test that separates wishers and whiners from doers" (p. 83).	3
FBT-5	GT-RB	"Sexaholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover" (p. 4). "Sexaholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover" (p. 4).	4
FBT-5	GT-SS	"Help from sponsor and group is indispensable here" (p. 3). "For most of us, without associating in some way with other recovering individuals, there is no lasting sobriety and none of the fringe benefits of recovery, growth, freedom, and joy" (p. 63).	7
FBT-5	GT-IC		0
FBT-5	GT-EAP	"Based on real or imagined injury, we create and hold on to a wrong toward another; we choose to distort the truth. Rebellion and hence resentment are born, (Perhaps a more inclusive term, sin, would be more appropriate)" (p. 48). "We take nourishment from the resentment; it sustains us. It sustains the new reality, which is a lie. It hides our wrong; we don't have to face it and deal with it. Thus, resentment is used as a drug" (p. 48).	24

FBT-5	GT-BS	"Find a weekly meeting place and set the time. At first, this may be a private home or office, where anonymity and privacy can be assured (pp. 173-174).	1
FBT-5	GT-WS		0
FBT-5	GT-ES		0

APPENDIX E: FBT Quotes of MBCT Key Components

EBT-5: Mindfulness-Based Cognitive Therapy

<i>Faith-Based Treatment</i>	<i>Codes</i>	<i>Examples</i>	<i>Frequency</i>
FBT-1	MBCT-FPMAA	The obsession interferes with her ability to remain emotionally present , with her sleep and work, and ultimately her interpersonal relationships" (p. 34). "It's important that she's able to stay in the moment and participate, rather than dissociate or disrupt the group" (p. 122).	3
FBT-1	MBCT-NJ		0
FBT-1	MBCT-NRM		0
FBT-1	MBCT-ETPE		0
FBT-1	MBCT-RDNR	"Triggers can be many things such as thoughts, emotions, or events that can begin the addictive cycle. A trigger can be something in the here and now, or a reaction to a perceived threat that the body identifies is similar to an earlier event" (p. 166).	1
FBT-1	MBCT-SR	"As the client's autonomic nervous system (ANS) begins to become regulated (a habit requiring practice to perfect), you can teach the FSLA simple bodily-based mindfulness and practice it in your office" (p. 190). "This basic mindfulness gradually builds her ability to recognize bodily clues to her feelings, since physical sensations and feelings are the best entry into buried emotions" (p. 190).	1
FBT-1	MBCT-BE	"Instruct her simply to ' notice and breathe '" (p. 197).	1
FBT-1	MBCT-CSEH	"As an alternative you can use guided imagery to create a safe place and envision help she can call on when needed" (p. 123). "Now you can introduce a simple somatic exercise. Begin...by having her ground her feet on the floor and feel her back body against the surface she's sitting on. Invite her to close her eyes...so you can verbally guide her through a mental body scan...notice the way her feet feel on the floor and in her shoes...ask her to breathe and to let the sensation go" (p. 197).	5
FBT-1	MBCT-RP	"As the client's autonomic nervous system (ANS) begins to become regulated (a habit requiring practice to perfect), you can teach the FSLA simple bodily-based mindfulness and practice it in your office. This basic mindfulness gradually builds her ability to recognize bodily clues to her feelings, since physical sensations and feelings are the best entry into buried emotions " (p. 190).	1

FBT-2	MBCT-FPMAA		0
FBT-2	MBCT-NJ		0
FBT-2	MBCT-NRM		0
FBT-2	MBCT-ETPE		0
FBT-2	MBCT-RDNR	"In recovery, addicts must be taught that they have choices about dealing with feelings . When they are tired and lonely and begin to fantasize, they should ask themselves, 'What does this fantasy mean? What am I feeling? Am I sad, lonely, afraid, or what?' They can call someone to talk to. They can go to a meeting. The key is learning to tell someone what the feelings are and getting support from them" (p. 154-bk).	1
FBT-2	MBCT-SR		0
FBT-2	MBCT-BE		0
FBT-2	MBCT-CSEH		0
FBT-2	MBCT-RP		0
FBT-3	MBCT-FPMAA		0
FBT-3	MBCT-NJ		0
FBT-3	MBCT-NRM		0
FBT-3	MBCT-ETPE		0
FBT-3	MBCT-RDNR		0
FBT-3	MBCT-SR		0
FBT-3	MBCT-BE		0
FBT-3	MBCT-CSEH		0
FBT-3	MBCT-RP		0
FBT-4	MBCT-FPMAA	"Our brains constantly scan our environment. The brain takes note of what's going on around us, and specifically, what we're doing" (p. 195-bk). "It records our feelings at the moment (I feel great today), as well as our body sensations (This chair sure is hard) and, finally, our comprehension of what's taking place (What's this guy getting at?) It stores that information on a continuous basis" (p. 195-bk).	3
FBT-4	MBCT-NJ		0
FBT-4	MBCT-NRM		0
FBT-4	MBCT-ETPE		0
FBT-4	MBCT-RDNR		0
FBT-4	MBCT-SR		0
FBT-4	MBCT-BE		0

FBT-4	MBCT-CSEH		0
FBT-4	MBCT-RP		0
FBT-5	MBCT-FPMAA		0
FBT-5	MBCT-NJ		0
FBT-5	MBCT-NRM		0
FBT-5	MBCT-ETPE	"For me the key was finally giving up all expectations of either sex or affection, and working on myself and my defective relations with others" (p. 24).	1
FBT-5	MBCT-RDNR		0
FBT-5	MBCT-SR		0
FBT-5	MBCT-BE		0
FBT-5	MBCT-CSEH		0
FBT-5	MBCT-RP		0