Women’s Sexual Addiction Group Proposal

TraciAnne Atkinson

Argosy University

**The Need for a Women’s Sexual Addiction Group**

Sexual addiction is a growing concern to those in the counseling profession. The rates of sexual addiction in the general population and in women specifically have been growing in recent years (McKeague, 2014; Opitz et all, 2009; Riemersma et all, 2013) and with that growth comes the need to develop treatments for those suffering with sexual addiction. Women’s sexual addiction is often rooted in a combination of trauma, shame and disconnection from those around them. (McKeague, 2014) Since disconnection is frequently one of the root causes of women’s sexual addiction it is logical and necessary to create groups to help women struggling with sexual addiction to overcome their shame and to enable them to connect with those around them. This article will endeavor to propose an outline for the creation and administration of one such group.

**Group Structure**

The proposed women’s sexual addiction group would meet every other week for a total of 6 sessions lasting for a span of approximately 3 months. Each group session will run for a period of 90 minutes. Since the group is of limited duration and women’s sexual addiction is an intricate and complex issue, it is recommended that the purpose of this group be refined to deal with a specific issue within women’s sexual addiction, leaving further work to be done with individuals within the group, to individual counselors or twelve step groups. It is recommended that individuals attending this group be already engaged in individual therapy and that they have done significant trauma work before being admitted to the group (McKeague, 2014). If trauma work has not been done it is unlikely that the woman would find this group to be as beneficial as it would be otherwise. Trauma work would allow for the specific triggers of each woman to be explored (McKeague, 2014) and thus avoided as much as possible in the group. Each woman should continue to participate in both individual therapy and a twelve-step group throughout the duration of this group. It is also recommended that each individual attend couples therapy where applicable. (McKeague, 2014; Riemersma et. All, 2013)

The purpose of the group will be to help sexually addicted women to overcome some of the root causes associated with sexual addiction in women, namely shame and disconnection. To accomplish this the group will have three main goals. The first goal of the group will be to identify what leads group members to feel shame. Some work on this goal should already have been accomplished during trauma work with an individual counselor or possibly with a trauma group. The second goal will be to help group members develop strategies to combat their feelings of shame and the causes of those feelings. The third goal of the group will be to assist each group member in creating meaningful connections within the group and in their personal life. It is hoped that by accomplishing these goals, the purpose of the group will be met and group members will be able to end the shame and isolation that perpetuates their addictions.

**Group Establishment**

As before mentioned trauma plays a major role in the lives of many sexual addicts. Often this trauma is the cause of specific triggers for an addict. It would be unethical to ignore this part of the diagnosis of sexual addiction. It is to ensure that this does not happen that the recommendations to admit only those who have already done significant trauma work and who continue to meet with individual counselors who could address further needs of their clients in terms of their trauma were made. It is therefore imperative that the screening processes for candidates for the women’s sexual addiction group include questions about trauma work done by the clients.

Since it is recommended that only clients who have done significant trauma work before with an individual or a group counselor be admitted into the women’s sexual addiction group, the most logical recruitment strategy would be to ask fellow counselors to recommend clients for admittance into the group. Considering that there is a high rate of comorbid diagnosis for women suffering with sexual addiction and other behavioral addictions as well as depression, eating disorders, and Borderline Personality Disorder and because many female sex addicts seek counseling for reasons other than sexual addiction (McKeague, 2014; Roller, 2004), counselors who are asked to recommend clients for admittance into the group should not be limited to those who work specifically in addictions. Rather requests for referrals should be given to as wide a base of presenting problems as possible in order to find those who struggle with this issue. That being said the group should stay at around 8-9 members.

Recruitment carried out in this way will also ensure that those who are struggling with a comorbidity diagnosis with another addiction or mental disorder are being treated for that diagnosis. This will help counselors to protect against the risk of the comorbid diagnosis of a client interfering with their recovery from their sexual addiction. (Opitz et all, 2009) This type of recruitment strategy however, does carry an ethical risk to the client’s confidentiality. It must be made clear to all counselors contacted, that they need their clients informed consent in order to refer them to the group. Counselors should not refer their clients to the group with out explaining to their clients what the group is, what its purpose is and how it intends to meet that purpose. Clients should be informed that prior trauma work may need to be discussed between their counselor and the group counselor in order to ensure that proper preparation has taken place. They and their counselor should discuss what this means in terms of the work they have done so far. If the client does not wish this information to be shared, the client should not be recommended to the group. (ACA, 2014)

**Leadership Analysis**

Having a male counselor lead this group can be a big, though not insurmountable, obstacle for this group. Many female sexual addicts have experienced sexual or physical abuse in their past (Opitz et all, 2009) and a male presence may prove threatening to them. Male counselors may also serve as potential triggers to female sexual addicts (McKeague, 2014). For these reasons it is generally advisable that the counselor for such groups be a female. As McKeague puts it “This will likely prevent erotic feelings form being triggered, and allows a female sex addict to establish a safe, trustworthy relationship without having to worry about potential triggers and boundary crossings.” One cultural group that this may not hold true for however, would be for members of the LGBT community. A female who identifies as lesbian may find a female counselor to be more a trigger than a male counselor would be. A transgender female may also find this to be true.

There is however, another solution that may prove beneficial. If the counselor who wishes to lead the group is male, it is advisable to have a co-leader for the group. This can help the group members to feel safe, especially if the co-leader is female and at the same time provides another counselor to help observe the group and support their fellow counselor. This support can often prove invaluable because of how complex sexual addiction can be and because countertransference is frequent when working with sexual addicts. (McKeague, 2014) Co-leading counselors can consult with each other when they believe this may be happening and can then seek appropriate support if further support is needed.

Group leaders should have experience in both experiential therapy and in Cognitive Behavioral Therapy. Experiential therapy will be used to help clients with interpersonal skills, as well as to develop trust and support. (Hagedorn et all, 2009) Once clients are able to improve these skills they will be able to connect with others and end their isolation. Cognitive Behavioral Therapy will be used to help clients reframe beliefs they hold that were formed by their shame. (Riemersma et all, 2013) These beliefs may includes ones such as the following: they are worthless; they are a bad or unworthy person; they are to blame for things that have happened to them; others cannot love them if they know about their addictions or the things that have happened to them and so on. (McKeague, 2014) Cognitive Behavioral Therapy can help clients to reframe these beliefs into more positive ones that can be productive in their lives. Both therapies will be needed in order to combat the targeted root causes of sexual addiction: shame and disconnection.

**Group Process Creation**

Since most female sexual addicts have experienced trauma in the form of sexual, physical or emotional abuse in their pasts it is extremely important that boundaries be very firmly established as soon as the group begins to meet. This should be done a the beginning of the first meeting, before even working on rapport exercises, because the clients are not likely to feel safe without these boundaries firmly in place. Establishing these boundaries, however, can go a long way towards establishing rapport in the group. Group members need to know that they will be safe in this environment.

Confidentiality should be especially stressed because extremely sensitive information is likely to be discussed and if confidentiality is broken it would be re-traumatizing for the member whose information was shared. Members should understand that information shared in the group as well as who was seen in the group should remain confidential. Any information shared by an individual within the group should be discussed only within the group setting. Although group members will not be asked to not have relationships outside of group, given that one of the main goals of group will be to help create connections in their lives, they will be told that they are not to discuss, even with each other, what has been shared within the group. In this way trust can be established between members. Should a breach in confidentiality occur, it should be addressed specifically with the person whose confidentiality was breeched before group and if the group member agrees then addressed within the group. The group should decide on what the proper consequence of the breech should be. (ACA, 2014)

The importance of respect should also be firmly established with this group. Again because most female addicts have struggled with abuse in one form or another it is important that they feel safe in this environment. This will happen much more quickly if they know that they will be treated with respect. Group members should be informed that no insults or threats to one another would be tolerated in this group. This is absolutely critical for the group to function. Insults and threats could quickly become re-traumatizing to members who have suffered from abuse on any kind and would destroy the trust needed for this group.

In the case of a threat or insult being made it is important to address it immediately and within the group. Group members need to see that the counselor can be trusted to confront those who break the group rules and that these types of comments really will not be tolerated. It will help establish a relationship of trust between the group members and the counselor. Counselors will need to confront the group member who made the comment directly and tell them that comment was against the rules that they agreed to and will not be tolerated. If the group member persists in threatening and insulting, she may need to be taken outside by the co-leader for a one-on-one discussion about why she is feeling the need to threaten and insult other group members.

Finally the group should be asked for their input on other rules that are important to them. This will help them to be involved in the group and feel as though they have a voice. It will also make sure that each woman has the opportunity to help shape the group into a place where she can feel safe.

**Intervention Identification**

The first session of the group should be spent mainly on establishing boundaries, rules and rapport. Boundaries and rules should be discussed first, as mentioned above so that members feel safe in the group and can participate more openly. The first session should be kept fairly light. Questions should be kept to those relatively easy to answer, only occasionally dipping a little deeper. Examples of such questions would be:

What do you like to do to relax?

Where do you feel safest?

What is your favorite place in the world and why?

Who are you closest to in your life?

If you could change one thing about any relationship in your life what would it be?

These questions would help group members to relax and would get them used to sharing with each other. They also would help group members to think about places where they have been safe and might help to associate the group with those feelings of safety. Finally some of these questions get group members thinking about the connections in their lives and what they can do to change them.

The second session should focus on shame. Counselors should share the following quote from Berne Brown “the difference between shame and guilt is best understood as the difference between ‘I am bad’ and ‘I did something bad.’ Guilt equals I did something bad. Shame equals I am bad.” (Brown, 2012) Ask the group what they think of this quote. Then counselors should ask questions that would prompt members to reflect on times they have felt shame and times they have felt guilt. Ask members if they would be willing to share. Group members should also be asked what they believe makes them feel shame vs. feeling guilt. Group leaders should remain very aware of body language and if group members are disengaging switch briefly to a lighter topic. Since the group is still in its earlier stages, probably in storming and norming, group members may still be struggling with feeling comfortable enough to share.

The third session should reflect back on the second. Ask group members to recall the experiences where they remembered feeling shame. Ask if anyone would be willing to share what their thought was at the time. Examples might be I felt worthless because… or I thought I was bad because… Ask the group how these beliefs can be reframed into more positive ones. Try to get everyone to share and to accept feedback form the group.

Since by now the group should be in the performing stage, the fourth session would revolve around an experiential therapy activity. One such activity would be crossing the swamp (Hagedorn et all, 2009). This is an activity in which the participants use the twelve steps written on pieces of paper as lily pads to leapfrog over each other to cross a swamp full of alligators, which represent the things that can go wrong in recovery. Participants are forced to rely on each other to reach the other side, they cannot lose contact with each other or any of the twelve steps as a team and no part of their bodies can touch the floor. Losing contact for the briefest moment with a step results in its removal by the group leader. During processing questions can be asked like What happened; what interfered with success; what steps did you keep/lose; how was your communication; what does this mean in terms of your recovery? This activity should help them to learn to rely on others in their recovery. If clients are uncomfortable with physical touch because of trauma or because of cultural background they may chose to simply observe and join the processing by sharing their observations.

The fifth session should focus on improving the group member’s connections to those around them. Ask group members to think back the first session when they were asked what was one thing they would change about any relationship they had and why? Ask them to think of one way they could improve the relationship they answered with at that time in the next two weeks. Ask if they would be willing to share with the group what they plan to do. Ask group members to write their goal down. Check up on how they did with these goals at the beginning of the next session.

The sixth session should be spent concluding the group. Ask group members how they did on their goals. Discuss how they feel about their relationship now. Ask group members to share what they have learned from the group and what they will use from the group going forward.

**Ethical and Legal Considerations**

One ethical issue that may arise is if an individual counselor recommends a woman for the group who is not informed previous to the recommendation about the group. To avoid this issue when proceeding with initial recruitment, counselors should be advised that clients must be informed before being recommended to the group (ACA, 2014). They must also be informed and sign a release if any information between the individual counselor and the group counselor regarding them is to be exchanged. (ACA, 2014) Clients must also be informed prior to answering the group evaluation questions, the nature and purpose of those questions and what the results will be used for. (ACA, 2014)

Another ethical issue already discussed above is that of not treating addiction as a whole and instead concentrating on just one part of it. This could be taken as not treating a presenting problem. Careful screening of potential clients to ensure that they have already had the needed trauma work and are continuing in individual counseling solves this issue.

**Group Evaluation**

In order to evaluate whether the group met its goals or not the counselor should ask group members to answer the following questions on a scale of 1-10 at the start of the group, and at the end of the group: Are you satisfied with the relationships in your life? How worthy do you see your self of love and belonging? Are you able to talk through your problems with someone close to you? How do you see yourself from good to bad, one being horrible and ten being amazing? Answers should be compared from how group members felt at the start of the group to how they felt at the end of group. If possible survey should be taken again at the end of another 6 months. Counselors should also ask the group during the last session how they felt the group went and if they felt anything should have been done differently.

**Proposal Summary**

In summary the woman’s sexual addictions group proposed would meet every other week for an approximate period of 3 months. There would be 6 sessions and each session would be for about 90 minutes. The group would target two root causes of woman’s sexual addiction: shame and disconnection. It would rely on experiential therapy to help treat disconnection and CBT therapy to help treat shame. The group would place heavy emphasis from the start on confidentiality and respect.

**Bibliography**

American Counseling Association. (2014). *ACA 2014 Code of Ethics* [Brochure]. Author. Retrieved 2016, from http://www.counseling.org/Resources/aca-code-of-ethics.pdf

Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. New York, NY: Gotham Books.

Hagedorn, W. B., & Hirshhorn, M. A. (2009, March). When Talking Won't Work: Implementing Experiential Group Activities with Addicted Clients. *Journal for Specialists in Group Work,* 43-67. Retrieved July 22, 2016, from Ebscohost.

McKeague, E. L. (2014). Differentiating the Female Sex Addict: A Literature Review Focused on Themes of Gender Difference Used to Inform Recommendations for Treating Women with Sex Addiction. *Sexual Addiction and Compulsivity,* 203-224. doi:10.1080/10720162.2014.931266

Opitz, D. M., Tsytsarev, S. V., & Froh, J. (2009). Women's Sexual Addiction and Family Dynamics, Depression and Substance Abuse. *Sexual Addiction and Compulsivity,* 324-340. doi:10.1080/10720160903375749

Riemersma, J., & Sytsma, M. (2013). A New Generation of Sexual Addiction. *Sexual Addiction and Compulsivity,* 306-322. doi:10.1080/10720162.2013.843067

Roller, C. G. (2004). Sex Addiction and Women: A Nursing Issue. *Journal of Addiction Nursing,* 33-61. doi:10.1080/10884600490450263