COMPULSIVE SEXUAL BEHAVIOR AND
PERSONALITY CHARACTERISTICS:
A COMPARATIVE ANALYSIS

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

by

Christopher J. Austin, B.S., M.S.
Denton, Texas
December, 1997
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The purpose of the present study was to compare the scores of the Beck Depression Inventory, State-Trait Anxiety Inventory, and the Coopersmith Inventory of heterosexual men with compulsive sexual behavior (N = 22), homosexual men with compulsive sexual behavior (N = 19), heterosexual men without compulsive sexual behavior (N = 38), and homosexual men without compulsive sexual behavior (N = 8). The Sex Addiction Screening Test was used to determined placement in a group. Findings revealed men who exhibit compulsive sexual behavior are significantly more depressed, experience lower self-esteem and have higher state anxiety (situational) than controls.
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CHAPTER 1

INTRODUCTION

There are a growing number of theories concerning a pattern of sexual behavior in which a person is excessively preoccupied with sexual thoughts or repetitive sexual behaviors to the point that the behavior becomes undesirable. Although there is quite a history of observing such behavior, it has only been in the past decade that certain sex behaviors have been hypothesized as agents for compulsive or addictive disorders (Coleman, 1986). Theories concerning the underlying motivation for this behavior abound. However, there is a paucity of studies which empirically validate the theories.

In a historical context, Kraft-Ebbing (1886/1965) describes a person's sexual desire that is highly increased:

...to such an extent that it permeates all his thoughts and feelings, allowing of no other aims in life, tumultously and in a rut-like fashion demanding gratification without granting the possibility of moral and righteous counter-presentations... This pathological sexuality is a dreadful scourge for its victim, for he is in constant danger of violating the laws of the state and morality, of losing his honor, his freedom and even his life. (pp. 46-47)

There is general agreement that a pattern of sexual behavior exists in which sexual thoughts persistently intrude and distract one's thoughts. Coleman (1987) states that a number of people are concerned about the excesses, lack of control, amount of
preoccupation and disruption of their lives as a result of their sexual behavior. Carnes (1989) includes the following behaviors in his classification of sex addiction:

1) exhibit a constellation of preferred sexual behaviors, arranged in a definite ritualized order, which are acted out in an obsessional scenario;

2) experience periods of escalation, de-escalation and acuity;

3) continue to act out despite serious consequences, including health risks, severe financial losses, injury, loss of family, and even death;

4) have delusional thought patterns, including rationalization, minimization, projection, reality distortion, and memory loss;

5) make futile repeated efforts to control the behavior even to the point of extreme hardship or self-mutilation;

6) experience little pleasure, often feeling despair even in the midst of sex;

7) spend most of the time in a state of obsession which subordinates life decisions, feelings, and self-awareness until reality comes crashing in;

8) feel shame and depression so severe that suicidal tendencies are one of the most common concurrent mental health issues;

9) experience withdrawal symptoms that parallel the depressive states of withdrawing cocaine addicts;

10) behave in a severely abusive and exploitive way, often violating his or her own values and common sense;

11) live a secret life surrounded by a web of lies and dishonesty which add to the accumulated shame;
12) go to extreme efforts to maintain appearances, including high achievements and excessive religiosity;

13) allow family relationships and friendships to become secondary in importance to obsessional and delusional patterns that are pathological and self destructive;

14) incur significant economic costs due to lack of productivity, increased health care costs, financial losses associated with maintaining the addiction. (pp. 5-6)

Review of the Literature

A review of the literature finds little consensus on whether the underlying cause is psychosexual, obsessive-compulsive, impulsive, or addictive. According to the theorist's particular bent, the behavior pattern has been labeled differently by various theorists and researchers. It has been called satyriasis (Auerback, 1968), sexual addiction (Carnes, 1983, 1989; Goodman, 1992; Schwartz & Brasted, 1985), sexual compulsivity (Coleman, 1987; Quadland, 1985; Weissberg & Levay, 1986), hypersexuality (Orford, 1978), and sexual narcissism (Hurlbert, Apt, Gasar, Wilson & Murphy, 1994). A review of the literature finds considerable controversy surrounding not only how this behavior should be designated, but even the validity of the behavior itself (Levine & Troiden, 1988). The following sections will describe the rationales and criticisms of each label.

Satyriasis

Satyriasis is excessive, uncontrolled sexual activity by a man with little or no emotional involvement (Auerback, 1968). The sexual drive of the individual is "constant, insatiable, impulsive and uncontrolled, involving many partners and of an unusual frequency, with no feelings of love for the partner" (Auerback, 1968, p. 38). The term
Satyriasis originates in Greek mythology. The satyr was a half man, half horse (or goat) who was renown for an insatiable appetite for sexual behavior (orgies) during various festivals. Satyrs were the embodiment of unrestrained nature and carnal appetites (Flaum, 1993).

Satyriasis in individuals is theorized to originate in disturbed relationships in the individual's early years (Auerback, 1968). Dysfunctional families are typically inconsistent in training and discipline and the parental relationship is in constant flux. The child learns that relationships are unstable and impermanent; at times overly loving and giving and other times overly rejecting, critical, or completely absent from the individual's life.

This type of upbringing generates the feeling that an emotionally close relationship with any person leads to the danger of being hurt. A boy growing up in this environment may experience confused feelings of love and hate, drawing to people for his need for affection but fearing or hating this need because it may cause him to be hurt by others. As the individual grows older, he is likely to feel deprived and deceived and use his sexual behavior in an attempt to make up for what he did not get while he was growing up. This person lacks sexual maturity, which hinders him from developing a lasting emotional bond with his sexual partner.

Auerback (1968) theorizes that a compulsive promiscuous individual attempts to solve problems through sexual behavior. The sexual activity is a safety valve for pent-up tensions, anxiety, anger, and hatred. The individual can not achieve satisfaction in his sexual relationships but rather maintains a safe emotional distance to avoid being hurt.
The problem with the construct of satyriasis is the mythological nature rather than the descriptive nature of what the term designates. Even if the reader is familiar with the mythological creature, its exact meaning is unclear and ill defined. It implies no underlying motivation and its vague definition makes empirical study of the behavior impossible. Therefore, given the problems in definition, satyriasis would be extremely difficult to empirically validate.

**Sexual Addiction**

Many theorists (Carnes, 1983, 1989; Earle & Crow, 1990; Goodman, 1992, 1993; Schwartz & Brasted, 1985) conceptualize excessive sexual behavior as sexual addiction or sexual dependency. To understand this behavior as an addiction, one must first know the definition of addiction and then determine if the behavior described fits the criteria for addiction. Goodman (1993) attempted to define addiction as "a disorder in which a behavior can function both to produce pleasure and to provide escape from internal discomfort. In addition, the individual has 1) recurrent failures to control the behavior, and 2) the continuation of the behavior despite significant harmful consequences" (Goodman, 1990, pp. 226-227). The diagnostic criteria for addiction in DSM format is listed in Appendix A.

The diagnostic criteria for sexual addiction in DSM format is listed in Appendix B. As listed, sexual addiction is not a bizarre aberration or a unique disease but rather is a disorder that meets a behaviorally nonspecific set of diagnostic criteria and motivating processes. It is also important to note the content of the sexual behavior is not considered
a sexual addiction, but rather the pattern of sexual behavior and how the behavior relates to and effects the person's life. Coleman states:

Any sexual behavior that can function both to produce gratification and to provide escape from internal discomfort has the potential to be engaged in addictively, but constitutes a sexual addiction only to the extent that it occurs in a pattern that meets the diagnostic criteria or coincides with the definition. It is not the type of behavior, its object, its frequency, or its social acceptability that determines whether a pattern of sexual behavior qualifies as sexual addiction; it is how this behavior relates to and affects the individual's life, as indicated by the definition and specified in the diagnostic criteria. (p. 231)

The study of sexual addiction was greatly enhanced by Carnes (1983) as evidenced by his book *Out of the Shadows*. Carnes compares sexual addiction to alcohol addiction by describing a sex addict's sexual thoughts and behavior become the most dominating factor in his life, more prominent than family, friends, and work. The addict feels isolated and lonely since the primary focus is upon sex, not on relationships with other people. Thus, a dysfunctional relationship to a sexual event substitutes healthy relationships with people. The mood altering experience becomes central, excluding most other relationships and activities. Carnes (1986) identifies a sex addict as "a person whose sexual behavior had become 'unstoppable' despite serious consequences" (p. 4).

Carnes (1991) defends the term "addiction" stating that brain chemicals are responsible for the "high" following sexual behavior. The chemicals that have an effect on the brain are endorphins, a peptide called phenylethylamine (PEA) and the enzyme MAO.
Several researchers have shown these chemicals alter brain functioning and are released in association with sexual activity/arousal (Liebowitz, 1983; Milkman & Sunderwirth, 1986; Zuckerman, 1983). Carnes states "to suggest that addiction can involve only chemicals external to the body is to dismiss the sex addict's reality" (p. 34).

From his clinical experience and research, Carnes (1991) identifies the following ten signs that indicate the presence of sexual addiction:

1) a pattern of out-of-control behavior;
2) severe consequences due to sexual behavior;
3) inability to stop despite adverse consequences;
4) persistent pursuit of self-destructive or high-risk behavior;
5) ongoing desire or effort to limit sexual behavior;
6) sexual obsession and fantasy as a primary coping strategy;
7) increasing amounts of sexual experience because the current level of activity is no longer sufficient;
8) severe mood changes around sexual activity;
9) inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual experience; and
10) neglect of important social, occupational, or recreational activities because of sexual behavior. (p. 12)

It is important to note that the identification of sexual addiction is not the quantity but rather the establishment of a pattern of behavior.
Carnes (1983, 1986) describes a four-step cycle that a person progresses through which intensifies as the cycle is repeated. The first step is preoccupation, which Carnes defined "as a trance-like state in which the addict's mind is completely engrossed with thoughts of sex." This is followed by ritualization, in which the addict performs routines and behaviors in order to intensify the preoccupation, adding more energy to the arousal and excitement. The third step is the compulsive sexual behavior, the actual sexual act, which is the unstoppable end goal of the first two steps. After the acting out, the fourth step is despair. At this point, the individual feels utterly hopeless about his behavior and powerless to control his life. This is a combination of a sense of failure at not having lived up to resolutions to stop and hopelessness about ever being able to stop. After the despair, the cycle is perpetuated when the sexual preoccupation replaces the despair.

Wolf (1988) also has observed a cyclical pattern in sex addiction. He states that the starting point for sexual addiction is a poor self image because "it appears to be the entry level or baseline status...in terms of a constant emotional undercurrent of depression or dissatisfaction with his life situation" (p. 140). Sex addicts may have a historical pattern of depressive ideation in response to stress, especially interpersonal stress. This may lead to the expectation of rejection by others which exists as a manifestation of the person's disappointment with himself and assuming others feel for him as he feels for himself.

Because of poor interpersonal skills and superficial relationships, the person feels an acute sense of isolation and withdrawal. In order to compensate for these negative feeling states, the individual begins to fantasize how his needs can be fulfilled, most often
through sexual fantasies. Wolf states that "this escape can be understood as a learned coping mechanism which develops fairly early in their lives out of a realization that sexual gratification is a way of displacing other more unpleasant emotional feelings" (p. 140). The fantasy cognitively rehearses the sexual behavior and increases the individual's attraction toward the fantasy behavior. This also increases the probability that the behavior will be actualized.

After the person has acted out the sexually inappropriate behavior, the individual experiences a "return to senses" and feels a fear of being caught or embarrassed by the wrongness of the behavior. Guilt is felt only for a brief time because "characterologically these are individuals who do not generally take responsibility for themselves or their behaviors" (Wolf, 1988, p. 141). This results in the person not learning from his mistakes which returns the individual to the original emotional state of low self worth. He again recognizes his failure, and because he can not cope with those feelings, he must deny the sexual problem. This results in a high probability of acting out again and perpetuating the cycle.

Earle and Crow (1989) describe sexual addiction as obsessions and compulsions. Obsessions occur as the sexually addictive cycle progresses. Sexual addicts report an overwhelming desire for sex and constant sexual thoughts that interfere with family relationships, friendships, work, and other responsibilities and/or activities. These persons report spending fifty percent or more of their time thinking about sex which results in sexual thoughts crowding out thoughts of the reality of daily living and functioning. The strong, uncontrollable preoccupation concerning sex becomes the focal point of their lives.
Earle and Crow state that "sex addicts are haunted by persistent, repetitive sexual thoughts that they rarely can ignore and often can stop by only engaging in the sexual activity with which they are obsessed" (p. 16).

Compulsions are repetitive behaviors or mental acts the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification (American Psychiatric Association, 1994). Similarly, Earle and Crow (1988) define compulsions as persistent repetitive behaviors that follow an obsession and are powerful when they result from an individual's need to relieve stress or escape from unpleasant feelings. The compulsion for sex addicts is a "virtually irresistible urge to repeat a behavior again and again, regardless of the immediate harm it can cause or its long-range consequences...overrides a sex addict's logical thinking, moral judgement, and even the strongest desire not to do the compulsive behavior" (p. 17). The individual is compelled to act out the behavior once the obsession persistently intrudes into the person's thinking.

Earle and Crow (1989) state that from clinical observation, all addicts have several common attributes including:

"1) a tendency to hold low opinions of themselves and to remind themselves constantly of their deficiencies;

2) distorted or unrealistic beliefs about themselves, their behavior, other people, and the events that occur in the world around them;

3) a desire to escape from or suppress unpleasant emotions;

4) difficulty coping with stress;
5) at least one powerful memory of an intense "high" experienced at a crucial time in their lives; and

6) an uncanny ability to deny that they have a problem" (p. 18).

Sexual addiction is considered progressive in nature in that the person uses more time and energy being caught in the cycle and less time pursuing healthy activities.

Coleman (1986) asserts that the cycle of sexual addiction often begins with a history of family intimacy dysfunction, such as child abuse (physical, emotional, psychological, and/or sexual), or neglect in the family of origin. The individual develops feelings of shame, worthlessness, and inadequacy as a response to the trauma. The intensity of these feelings then causes an interruption in normal, healthy social functioning leaving the individual feeling lonely and with some degree of psychological distress. It is in response to this pain that the individual searches for a way to alleviate the pain and provide temporary relief. The sexual addict uses sexual behavior as the vehicle to escape his pain.

Using sexual behavior as a temporary respite from pain, however, means that the person must attempt to achieve a series of sexual encounters to provide the necessary lasting relief. Thus, the behavior becomes repetitive and begins a cycle that "simply feeds a greater need to engage in the behavior of its analgesic qualities" (Coleman, 1986, p. 9). The individual also begins feeling an ever increasing amount of shame as the sexual addiction progresses. This further impedes healthy interpersonal relationships and produces more psychological distress. The chaos this cycle produces only continues to mask the individual's low self esteem, loneliness, and pain.
Schwartz and Brasted (1985) describe sex addiction as a disorder of intimacy in which the individual has "difficulty consistently combining sexuality and closeness with a desired partner" (p. 106). They theorize that acting-out behavior is a means of coping with stress in the individual's personal or occupational life. However, when the individual ineffectively copes by sexually acting out, the problems remain unresolved. Escape from the problem with sexual behavior only perpetuates a cycle in which stress is never resolved and the individual engages in "more of the same" behavior which continues the cycle.

When the cycle is in effect, the individual is confused by his inability to control many aspects of his life (Schwartz & Brasted, 1985). The sexual behavior becomes an arena in which the individual feels he can get what he wants, and the only area that brings pleasure to his life. However, once he has exhibited the behavior, he is left with feelings of inadequacy, anxiety, depression, and loneliness. Each time he acts out his sexual addiction, he repeatedly pledges to discontinue the behavior but is unable to stop the cycle.

Although there is much theoretical research and experienced observation in the area of sexual addiction, there is a paucity of empirical research concerning sexual addiction. Through observation, theorists have suggested that sex addicts have elevated levels of anxiety (Eber, 1981; Wolf, 1988), depression (Levine, 1982), obsessive-compulsiveness (Carnes, 1983), and interpersonal sensitivity (Carnes, 1983; Wolf, 1988). Raviv (1993) studied these hypothesized personality characteristics by comparing 32 self identified sexual addicts to a group of 38 non-addicts. Subjects were given the SCL-90-R to determine their levels of anxiety, depression, obsessive-compulsiveness, and
interpersonal sensitivity. The Sensation-Seeking Scale was used to measure the person’s need for stimulation and arousal while the Self-Defeating Personality Disorder Scale was administered to determine the number of self-defeating behaviors in which the person engages. Results indicated that persons who identified themselves as sex addicts were significantly more anxious, depressed, obsessive-compulsive, and interpersonally sensitive than individuals in a non-addict group.

Coleman (1991) states "addiction" is an inappropriate label since there is no known interaction between a substance and the brain. He suggests the term addiction should be used more as a metaphor instead of scientific terminology for the cycle of sexual behavior. Barth and Kinder (1987) are critical of the label "addiction" because the "behavioral similarities do not overrule the original definition of addiction as a physiological dependence on a foreign substance, evidenced by the removal of that substance producing a physiological withdrawal state" (p. 21).

According to Coleman (1992), the term "addiction" oversimplifies a complex biopsychosocial phenomenon and thus prevents recognition of concomitant neuropsychiatric disorders and the treatment of those disorders with the appropriate medical treatment (Coleman, 1991). This means the conventional treatment of addiction is inadequate in addressing the needs of compulsive sexual behavior. In addition, conceptualizing the behavior as an addiction might thwart attempts to ask more complex questions and take into account individual differences to develop individualized treatment approaches (Coleman 1990).
Coleman (1992) refers to sexual addiction as an unfortunate misnomer. He states "people do not become addicted to sex in the same way they become addicted to alcohol or other drugs...Sexual addiction has become a popular metaphor similar to 'workaholism' but the term sexual addiction obviates the complex interplay of biological, social and psychological factors that cause the behavior" (p. 321).

Other theorists (Levine & Troiden, 1988) are critical of any attempts to label any sexual behavior as an "addiction" or "compulsion" because of the cultural relativity. They agree with Szasz (1970) who referred to any mental illness as a derogatory label for "problems" (p. 70) in living which deviate from "psychosocial and ethical standards" (p. 70). Levine and Troiden (1988) state the:

- diagnosis of sexual addiction or compulsion rests on culturally induced perceptions of what constitutes sexual impulse control. Perceptions of control over erotic impulses, however, are social constructions. Definitions of "controlled" and "uncontrolled" sexuality are cultural inventions specific to particular societies at particular times...What one society regards as being sexually "out of control" or deviant, may or may not be viewed as such in another culture. (p. 351)

They continue by stating "there is nothing intrinsically pathological in the behavior that falls into the category of psychosexual disorders, they are defined as pathological only because they violate erotic norms...psychosexual disorders denote forms of stigmatized erotic conduct" (p. 355).

Levine and Troiden (1988) argue that the terms "sexual addiction" and "sexual compulsion" are merely value laden norms and give eight criticisms of the concept of
sexual addiction. First, sex is an experience instead of a substance, thus abrupt withdrawal from sexual behavior does not lead to forms of physiological distress such as diarrhea, delirium, convulsions or death, as would happen in substance abuse. Second, sex is the only addiction in which the addict is not expected to give up his "drug" during treatment as long as it is in appropriate context. This makes sexual expression appropriate only when it occurs within cultural norms and thus pathologized when it falls outside the cultural norm. Third, research has failed to document the existence of sexual addiction as a clinical condition. Fourth, sexual addiction is not a disease, but rather is a behavior whose meaning is mediated in a cultural context. Fifth, the research has found few if any significant differences and no clinical differences in the psychological profiles of compulsives and noncompulsives. Sixth, moralism affects current theory and conceptualization of sexual addiction. The behavior is not intended for procreation but is rather for pleasure or recreation (making it a behavior that is outside traditional values and mores), but is not necessarily a scientific fact or clinical syndrome. Seventh, the signs of sexual addiction (i.e., secrecy, abusiveness, painfulness, and emptiness) are subjective and may be judged and experienced differently by different persons. Finally, equally subjective are the terms in the addictive cycle (i.e., preoccupation, ritualization, despair, and compulsive sexual behavior) in that no clear norm can be established. The position of Levine and Troiden is summed up in the following statement:

We argue that sexual addiction and sexual compulsion represent pseudoscientific codifications of prevailing erotic values rather than bona fide clinical entities. The concepts of sexual addiction and sexual compulsion constitute an attempt to
repathologize forms of erotic behavior that became acceptable in the 1960s and
1970s. (p. 349)

**Sexual Impulsivity**

Barth and Kinder (1987) labeled the pattern of excessive sexual behavior as sexual
impulsivity. The rationale for this label focuses not on the frequency, promiscuity, or
social acceptability of sexual behavior but rather on the individual's perceived lack of
control over sexual impulses. The following description of Atypical Impulse Control
Disorder in the *Diagnostic and statistical manual of mental disorders* (American
Psychiatric Association, 1980) was used to understand excessive sexual behavior:

1. Failure to resist an impulse, drive, or temptation that is harmful to the individual
or others. There may or may not be conscious resistance to the impulse. The act
may or may not be premeditated or planned.

2. An increasing sense of tension before committing the act.

3. An experience of either pleasure, gratification, or release at the time of
committing the act. The act is ego-syntonic in that it is consonant with the
immediate conscious wish of the individual. Immediately following the act there
may or may not be genuine regret, self-reproach, or guilt. (p. 291)

The potential problem with this diagnostic label is the requirement that "such
disorders must involve some threat of harm to the individual or to others" (Barth &
Kinder, 1987, p. 22). However, given the risk of coming in contact with a sexually
transmitted disease such as herpes and Acquired Immune Deficiency Syndrome (AIDS),
the health risk is obvious not only for the individual but also for his partners. In addition,
the failure to control one's sexual behavior could likely impair the person's social and emotional health. Therefore, Barth and Kinder (1987) suggest that excessive sexual behavior be thought of more as a manifestation of an Atypical Impulse Control Disorder.

**Hypersexuality**

As one of the first theorists concerning the area of excessive sexual behavior, Orford (1978) preferred the label hypersexuality. He states that there is sufficient evidence to conclude that "excessive heterosexuality" exists because of the number of people that sought help to restrain their sexual behavior and were unable to get control. It is hypothesized that there are two reasons this sexual behavior is similar to dependence.

First, as with most consuming behaviors, one would expect that the availability of a reinforcing activity will result in the population statistically distributing itself along a distribution curve. Orford continues:

> Whatever the activity, the majority engage in it in moderation or not at all. Fewer and fewer people do more and more of it...the strongest users are likely to be those with strongest appetite for the activity concerned, the incurring of costs create conflict and dissonance about behavior. As heterosexual behavior must be rated one of the most rewarding of activities widely available, it would be most surprising if there were no dissonant or 'compulsive' heterosexuals. (p. 308)

Other evidence that the behavior exists is that it parallels the accounts of excessive drinkers, drug addicts, and gamblers. Each contains a reference of having "uncontrollable" desire and being driven to perform the behavior, preoccupation, failed attempts at self control, and other characteristics similar to dependence.
Sexual Narcissism

Other theorists (Hurlbert, Apt, Gasar, Wilson & Murphy, 1994) label the pattern of excessive sexual behavior as sexual narcissism. The diagnosis of sexual narcissism is proposed for individuals who evidence long-term patterns of chronic relationship intimacy dysfunction and "who are preoccupied with sex, yet can evidence negative attitudes toward sex and have low levels of sexual satisfaction" (p. 25). The authors propose that the essential features of sexual narcissism are similar to those of the Narcissistic Personality Disorder outlined in the DSM-III-R (American Psychiatric Association, 1987). The traits that sexual narcissists exhibit are "interpersonal exploitation, low self esteem, sense of entitlement, self-importance, inability to experience emotional intimacy and a lack of empathy" (p. 25).

Although some characteristics of the proposed diagnosis are similar to sexual compulsivity, the phenomena of sexual narcissism is different in some key areas. The diagnosis of sexual narcissism is for violent or sexually demanding individuals, whereas that may not be the case for most sexually compulsive individuals. Also, the key elements of sexual compulsion such as the obsessions and the repetitiveness of the behavior are not addressed. The phenomenon of sexual narcissism may exist but it is different from sexual compulsive behavior.

Sexual Compulsion

The DSM-IV (1994) defines compulsions as:

...repetitive behaviors or mental acts the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases the
person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation....By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are designed to neutralize or prevent....By definition, adults...have at some point recognized that the obsessions or compulsions are excessive or unreasonable. (p. 418)

Some theorists (Coleman, 1987; Pincu, 1989; Quadland, 1985; Weissberg & Brasted, 1986) view a pattern of excessive sexual behavior as a compulsion. Compulsive sexual behavior is a pattern of behavior designed to avert anxiety or some other painful affect (Weissberg & Levay, 1986) and distract the individual from the painful realities of life (Coleman, 1987).

Coleman (1987) states there are no differences demonstrated in sexual behavior between "normal" persons who are highly active sexually and "abnormal" persons with compulsive sexual behavior. However, the sexually compulsive individual is defined and described as one who is:

...preoccupied with certain patterns of sexual behavior and as a result of this preoccupation, experiences negative consequences following engaging in this behavior. Yet in spite of the negative consequences, the individual experiences great difficulty and many frustrated attempts to change his or her behavior. Individuals become preoccupied with sexual behavior such as pornography, prostitution, masturbation, sexual intercourse, affairs, anonymous sexual encounters, and certain fetishistic behaviors. (p. 190-191)
The sexual compulsive person doesn't simply seek out sex to survive and satisfy his body's needs. Instead, he seeks out sexual activity in order to cope with, to forget about, to escape from, or to anesthetize the pain in his or her life (Coleman, 1987).

Weissberg and Levay (1985) report that sexual compulsive behavior is aimed primarily at avoiding unpleasant affect. Pleasure is not of primary importance because the behavior many times yields only minimal pleasure or may even be painful. Instead of being motivated by a hedonistic desire for more and more pleasure, sexually compulsive behavior is motivated more by the relief of distress and discomfort.

There is general consensus among researchers that compulsive sexual behavior is anxiety based (Carnes, 1983, 1991; Coleman, 1986; Quadland, 1985). However, no significant differences of anxiety have been found between sexual compulsives and noncompulsives (Quadland, 1985). In Quadland's (1985) study of 30 homosexual subjects, it was found that sexual compulsives did not differ significantly concerning levels of frustration, anxiety, or loneliness from noncompulsives. However, it was found that men who identified themselves as having compulsive sexual behavior (CSB) had significantly more partners per month (13.7) than a control group (3.5) over the past five years. When comparing the number of partners per month in their most active year, the CSB group averaged 29.1 while the control group averaged only 9.4. Thus, it was determined that the CSB group differed from controls in the frequency and type of sexual behavior but not in underlying personality characteristics.

Critics state that labeling the disorder as "compulsive sexual behavior" is a mistake because the use of the compulsion concept in the context of sexual behavior is
"inconsistent with either of the DSM-III's two usages of the term compulsive" (Barth & Kinder, 1987, p.21). The term compulsive used in the context of sexual behavior does not fit the description of compulsive in the diagnosis of Obsessive-Compulsive Personality Disorder (American Psychiatric Association, 1994) because there is no element of perfectionism, orderliness, or preoccupation with details to the extent that the major point of an activity is lost. Neither does the term compulsive as used for sexual behavior fit for the description of compulsive in the diagnosis of Obsessive-Compulsive Disorder (American Psychiatric Association, 1994) as there is no clear indication that the behavior is intended to prevent or reduce distress or prevent some dreaded event or situation.

Levine and Troiden (1988) are critical of labeling excessive sexual behavior as compulsive because the major symptom of sexual compulsion is the individual's perception that his sexual behavior is out of control. They argue when perceptions of control are involved, the problem of subjectivity and moralism is created. Therefore, the assessment of what is "in control" and what is "out of control" is weighted heavily by the therapist's value orientation and purposes.

As noted throughout the literature, the lack of consensus on an appropriate label for this behavioral pattern severely hampers research and treatment. Although many labels have been examined, this paper will refer to the behavioral pattern as sexual compulsivity because research has failed to show that the underlying causes are incongruent with that label. This study will help determine possible underlying causes of this sexual disorder.
Rationale

The purpose of this study is to perform comparative analyses of the level of several personality characteristics in four groups of men: 1) homosexual men with compulsive sexual behavior, 2) heterosexual men with compulsive sexual behavior, 3) homosexual men without compulsive sexual behavior and 4) heterosexual men who do not report any compulsive sexual behavior.

Compulsive sexual behavior has received more attention in the last decade due to increased awareness of sexually transmitted diseases such as AIDS and herpes, and the health consequences of contracting these diseases. During the past few years, many persons have unsuccessfully attempted to decrease their number of sexual partners, despite the high probability of disease. This study may help identify anxiety, depression, or low self-esteem as underlying foundations of compulsive sexual behavior and thus aid in the definition, nomenclature, and treatment of this behavior. This study will add to the literature for psychologists to more effectively help these men change their unwanted behavior.

Many theorists (Carnes, 1987; Schwartz & Brasted, 1985; Quadland, 1985) have hypothesized that anxiety, depression and low self-esteem are factors in compulsive sexual behavior but there is currently no empirical research to back such claims. The purpose of this study is to test out those theories' claims concerning this subject.
CHAPTER 2

METHOD

Subjects

The subjects (N = 87) for the study were recruited from Sex Addicts Anonymous, Homosexual Anonymous Fellowship, from religious organizations and men's groups who agreed to participate. Each man signed an agreement to participate that was kept separate from his questionnaires and test results for confidentiality. The determination of sexual compulsion in the experimental groups was a score of 13 or more affirmative answers on the Sexual Addiction Screening Test (SAST) (see Appendix D). Twenty-two heterosexual and 19 homosexual men endorsed 13 or more items on the SAST while the noncompulsive group was made up of 38 heterosexual and 8 homosexual men who scored fewer than 13 on the SAST. The groups were comprised of men similar in age and education (see Table 1).

Heterosexual Sexual Compulsives

The 22 heterosexual men who endorsed 13 or more items on the SAST had a mean age of 31.95 and ranged in age from 28 to 37 years. In this group, 16 men were married (72.7%), five (22.7%) were single and one (4.5%) was divorced. High school graduates made up 40.9% of this group, 40.9% had graduated from college and 18.2% completed a graduate degree. The mean income for this group was $35,818 with a range from $22,000 to $70,000. Of the 22 men, 19 (86.4%) endorsed themselves as Caucasian,

one (4.5%) identified himself as Hispanic and two (9.1%) identified themselves as African American. Sixteen men (72.7%) endorsed satisfaction with their current sexual behavior and 17 (77.3%) endorsed being satisfied with their sexual orientation. Five men (22.7%) expressed dissatisfaction with their sexual orientation. Seventeen (77.3%) were in a committed relationship.

Twenty-one men (95.5%) identified themselves as Protestant, one man (4.5%) reported no religion. Of this group, 14 men (63.6%) reported attending religious services more than once a week, seven men (31.8%) attended services less than once a week and one (4.5%) reported never attending religious services. Concerning the importance of religion or spirituality, eighteen men (81.8%) regarded religion or spirituality as very important, and three (13.6%) considered it somewhat important and one (4.5%) considered it not important. The Likert scale rating religiosity (1 = Not Religious - 5 = Very Religious) revealed a mean of 3.455, one (4.5%) reported a 1, two men (9.1%) endorsed a 2, six (27.3%) reported a 3, twelve (54.5%) reported a 4, and one (4.5%) reported a 5.

The Likert scale rating their satisfaction with their sexual behavior (1 = Very Satisfied - 5 = Very Dissatisfied), revealed a mean of 3.455 with one subject (4.5%) reporting a 1, four men (18.2%) reporting a 2, seven (31.8%) reporting a 3, four (18.2%) endorsing a 4, and six (27.3%) endorsing a 5. The Likert scale rating their satisfaction with their sexual thoughts (1 = Very Satisfied - 5 = Very Dissatisfied), revealed a mean of 3.364 with six men (27.3%) reporting a 2, six (27.3%) reporting a 3, six (27.3%) endorsing a 4, and four subjects (18.2%) endorsing a 5. The Likert scale rating their
satisfaction with their sexual fantasies (1 = Very Satisfied, 5 = Very Dissatisfied), revealed a mean of 3.22 with two participants (9.1%) endorsing a 1, four (18.2%) reporting a 2, seven men (31.8%) reporting a 3, five (22.7%) endorsing a 4, and four (18.2%) endorsing a 5.

Twelve of the twenty (54.5%) in this group reported some homosexual experience. Three (13.6%) of the men reported one incident, three (13.6%) reported occasional experience, and six (27.3%) reported frequent homosexual experience. Nine (40.9%) of the men reported that they had put themselves at risk for a sexually transmitted disease. On frequency of sexual behavior (with or without a partner), four men (18.2%) reported more than once a day, three (13.6%) reported weekly sexual behavior, two (9.1%) reported monthly sexual behavior, two (9.1%) reported daily sexual contact, and 11 (50%) reported sexual behavior 2-5 times a week.

The Likert scale rating the severity of sexual abuse before age fifteen (1 = Not at all - 5 = Severe), revealed a mean of 1.682, with 14 participants (63.6%) reporting a 1, three (13.6%) endorsing a 2, three subjects (13.6%) reporting a 3, and two (9.1%) endorsing a 4. Eight of the men (36.4) reported being sexually molested or abused as a child. The ages of molestation were four, five, seven, nine, ten and fourteen. One man reported just one incident, six reported it happened occasionally, and one reported the abuse happened often. Two men reported that the abuser was an adult stranger while six reported the abuser was a relative.

The Likert scale on relationship with father (1 = Very Good - 5 = Very Poor) revealed a mean of 3.227 with four subjects (18.2%) reporting a 1, five (22.7%) reporting
a 2, two (9.1%) reporting a 3, four (18.2%) reporting a 4, and seven (31.8%) reporting a 5. The Likert scale on relationship with mother (1 = Very Good - 5 = Very Poor) revealed a mean of 2.636 with four men (18.2%) reporting a 1, seven (31.8%) reporting a 2, four (18.2%) reporting a 3, and seven (31.8%) reporting a 4. The Likert scale rating the severity of physical abuse before age fifteen (1 = Not at all - 5 = Severe) revealed a mean score of 2.227 with eight subjects (36.4%) reporting a 1, eight (36.4%) reporting a 2, one (4.5%) reporting a 3, three (13.6%) reporting a 4, and two (9.1%) reporting a 5. A Likert scale rating the severity of emotional abuse (1 = Not at all - 5 = Severe) revealed a mean score of 2.545 with six participants (27.3%) reporting a 1, eight (36.4%) reporting a 2, one (4.5%) reporting a 3, four (18.2%) reporting a 4, and three (13.6%) reporting a 5. The Likert scale of current overall satisfaction with life (1 = Very Satisfied - 5 = Very Dissatisfied) revealed a mean score of 2.909 with one man (4.5%) reporting a 1, eight men (36.4%) reporting a 2, six (27.3%) reporting a 3, six (27.3%) reporting a 4, and one (4.5%) endorsing a 5.

**Homosexual Sexual Compulsives**

The 19 homosexual men who endorsed 13 or more affirmative answers on the SAST had a mean age of 33.26 with an age range of 28 to 40 years. Most of the men were single (63.2%), five were married (26.3%) and two (10.5%) were divorced. College graduates made up 63.2%, while four (21.1%) had only a high school degree and three men (15.8%) had a graduate degree. The mean income for this group was $43,342.10 with a range from $5000 to $165,000. Seventeen (89.5%) identified themselves as Caucasian and two identified themselves as African American. Ten of the 19 (52.6%)
reported they were satisfied with their current sexual behavior and sexual orientation. Ten (52.6%) were not in a committed relationship.

Thirteen men (68.4%) identified themselves as Protestant, four (21.1%) identified themselves as no religion. Of this group, five (26.3%) reported that they never attend religious services, five (26.3%) reported they attend services less than once a week, and nine (47.4%) reported they attend religious services more than once a week. Concerning the importance of religion or spirituality in their life, ten men (52.6%) reported it as very important, five (26.3%) reported it as somewhat important, and four (21.1%) reported it as not important. The Likert scale rating how religious they were (1 = Not Religious - 5 = Very Religious) revealed a mean score of 3.263, four men (21.1%) endorsed a 1, two (10.5%) endorsed a 2, three (15.8%) endorsed a 3, five (26.3%) reported a 4, and five subjects (26.3%) reported a 5.

On satisfaction with their sexual behavior, the mean was 3.579 (1 = Very Satisfied - 5 = Very Dissatisfied), five men (26.3%) endorsed a 2, four (26.3%) reported a 3, four (26.3%) endorsed a 4, and six (31.6%) endorsed a 5. On their satisfaction with their sexual thoughts, the mean was 3.789 (1 = Very Satisfied - 5 = Very Dissatisfied), three participants (15.8%) endorsed a 2, four (21.1%) reported a 3, eight (42.1%) reported a 4, and five (26.3%) endorsed a 5. On satisfaction with their sexual fantasies, the mean was 3.632 (1 = Very Satisfied - 5 = Very Dissatisfied), three men (15.8%) endorsed a 2, six (31.6%) reported a 3, five (26.3%) endorsed a 4, and five subjects (26.3%) endorsed a 5.

All 19 men reported they had homosexual sexual experience, 13 (68.4%) reported ongoing contact, five (26.3%) reported frequent homosexual contact, and one (5.3%)
reported only occasional contact. Eighteen men (94.7%) responded they had put themselves at risk to contract a sexually transmitted disease in the past year. On frequency of sexual behavior (with or without a partner), seven men (36.8%) reported more than once a day, two (10.5%) reported weekly sexual behavior, four (21.1%) reported daily sexual behavior, four (21.1%) reported more than once a week, and one (5.3%) reported rarely.

The Likert scale rating the severity of sexual abuse before age 15 (1 = Not at all - 5 = Severe) revealed a mean of 2.421. Nine men (47.4%) reported a 1, two (10.5%) endorsed a 2, six (31.6%) reported a 3, one (5.3%) reported a 4, and five (26.3%) reported a 5. Eleven of the 19 (57.9%) reported they had been sexually molested/abused as a child. Their ages of abuse were one, five, six, eight, nine, eleven, twelve, and fifteen. Of those who reported abuse, one (5.3%) indicated it happened only once, five (26.3%) indicated it happened occasionally, three (15.8%) reported it happened often, and two (10.5%) reported the abuse was ongoing in childhood. Eight men (42.1%) reported the abuser was a relative and three men (15.8%) reported the abuser was a person in authority.

The Likert scale on the relationship with father (1 = Very Good - 5 = Very Poor) revealed a mean of 4.368 with one (5.3%) reporting a 2, two (10.5%) reporting a 3, five (26.3%) reporting a 4, and 11 (57.9%) reporting a 5. The Likert scale on the relationship with mother (1 = Very Good - 5 = Very Poor) revealed a mean score of 2.947 with one man (5.3%) reporting a 1, seven (36.8%) reporting a 2, five (26.3%) reporting a 3, four (21.1%) reporting a 4, and two (10.5%) reporting a 5. The Likert scale rating the severity
of physical abuse (1 = Not at all - 5 = Severe) revealed a mean of 2.6 with six men (31.6%) reporting a 1, four (21.1%) reporting a 2, four (21.1%) reporting a 3, one (5.3%) reporting a 4, and four (21.1%) reporting a 5. The Likert scale rating their overall satisfaction with life (1 = Very Satisfied - 5 = Very Dissatisfied) revealed a mean of 3.474 with five men (26.3%) reporting a 2, four (21.1%) reporting a 3, six (31.6%) reporting a 4, and four (21.1%) reporting a 5.

Heterosexual Noncompulsives

The 38 heterosexual men who scored less than 13 on the SAST had a mean age of 34.4 and ranged in age from 27 to 40 years. In this group, 34 men (89.5%) endorsed married, three (7.9%) endorsed single, and one (2.6%) endorsed divorced. College graduates made up 65.8% of the sample, 13.2% had only a high school degree, and 21.1% endorsed having a graduate degree. The mean income for this group was $57,342 and ranged from $25,000 to $150,000. Of the 38 men, all endorsed being Caucasian. All reported being satisfied with their sexual orientation, and 97.4% endorsed being in a committed relationship.

Thirty-five of the 38 (92.1%) endorsed being Protestant while three others (7.9%) endorsed being Catholic. Of this group, seven men (18.4%) reported attending religious services less than once a week and 31 (81.6%) reported they attend more than once a week. Concerning the importance of religion or spirituality in their life, 37 men (97.4%) reported very important, and one man (2.6%) reported somewhat important. The Likert scale rating how religious they were (1 = Not Religious - 5 = Very Religious) revealed a
mean score of 4.363 with six men (15.8%) reporting a 3, sixteen (42.1%) endorsing a 4, and sixteen (42.1%) reporting a 5.

On their satisfaction with their sexual behavior, the mean was 2.289 (1 = Very Satisfied - 5 = Very Dissatisfied) with 13 men (34.2%) endorsing a 1, 11 (28.9%) endorsing a 2, seven (18.4%) endorsing a 3, four (10.5%) endorsing a 4, and three (7.9%) endorsing a 5. On satisfaction with their sexual thoughts (1 = Very Satisfied - 5 = Very Dissatisfied), the mean was 2.211 with 11 men (28.9%) endorsing a 1, 13 (34.2%) endorsing a 2, nine (23.7%) endorsing a 3, and five (13.2%) reporting a 5. On satisfaction with their sexual fantasies (1 = Very Satisfied - 5 = Very Dissatisfied), the mean was 2.263 with eight men (21.1%) endorsing a 1, 16 (42.1%) endorsing a 2, ten (26.3%) reporting a 3, and four (10.5%) reporting a 4.

Six men (15.8%) of this group reported prior homosexual experience. Of these, five reported a single incident and one reported occasional incidences. One man (2.6%) reported that he had put himself at risk to contract a sexually transmitted disease in the past year while 37 (97.4%) reported they had not. On the frequency of sexual behavior (with or without a partner), one man (2.6%) reported having sexual behavior more than once a day, one (2.6%) reported daily sexual behavior, 17 (44.7%) endorsed sexual behavior more than once a week, 15 men (39.5%) reported weekly sexual behavior, three men (7.9%) reported monthly sexual behavior, and one man (2.6%) reported he engaged in sexual behavior only rarely.

On the Likert scale rating the severity of sexual abuse before age 15 (1 = Not at all - 5 = Severe) only one man (2.6%) reported a 4; all others in the sample endorsed a 1.
Two men (5.3%) endorsed being sexually abused/molested. One at age seven and the other did not give an age. Both reported the abuse or molestation happened once, one reported that the abuser was an adult stranger and the other reported the abuser was a person in authority.

The Likert scale rating the relationship with father (1 = Very Good - 5 = Very Poor) revealed a mean of 1.974 with 16 men (42.4%) reporting a 1, nine (23.7%) reporting a 2, 11 (28.9%) reporting a 3, and two (5.3%) reporting a 4. The Likert scale rating the relationship with mother (1 = Very Good - 5 = Very Poor) revealed a mean of 1.632 with 18 men (47.4%) reporting a 1, 16 (42.1%) reporting a 2, and four (10.5%) reporting a 3. The Likert scale rating the severity of physical abuse before age 15 (1 = Not at all - 5 = Severe) revealed a mean of 1.132 with 36 men reporting a 1, one (2.6%) reporting a 3, and one (2.6%) endorsing a 4. The Likert scale rating their emotional abuse before age 15 (1 = Not at all - 5 = Severe) revealed a mean of 1.5 with 25 men (65.8%) reporting a 1, nine (23.7%) reporting a 2, two participants (5.3%) reporting a 3, and two (5.3%) reporting a 4. The Likert scale rating their overall satisfaction with life (1 = Very Satisfied - 5 = Very Dissatisfied) revealed a mean of 1.974 with 11 men (28.9%) endorsing a 1, 20 (52.6%) endorsing a 2, four (10.5%) endorsing a 3, and three (7.9%) reporting a 4.

**Homosexual Noncompulsives**

The eight homosexual men who scored less than 12 on the SAST had a mean age of 32.250 and ranged in age from 28 to 38 years. In this group, seven men (87.5%) endorsed being single and one man (12.5%) endorsed being married. High school
graduates made up 50% (4) of this group while one (12.5%) had a college degree and three (37.5%) had completed a graduate degree. The mean income for the group was $31,000 with a range from $12,000 to $60,000. Of the eight men, all endorsed being Caucasian. All reported satisfaction with their sexual orientation and sexual behavior and seven men (87.5%) reported they were not currently in a committed relationship.

Five men (62.5%) reported they were Protestant, one (12.5%) endorsed being Catholic, and two (25%) reported no religion. Of this group, two men (25%) reported never attending religious services while the other six (75%) reported attending religious services more than once a week. Concerning the importance of religion or spirituality in their life, six men (75%) reported very important, one (12.5%) reported somewhat important, and one (12.5%) reported not important. The Likert scale rating how religious they are revealed a mean score 3.625 with one man (12.5%) reporting a 1, one (12.5%) endorsing a 2, four (50%) endorsing a four, a 2 (25%) reporting a 5.

On satisfaction with their current sexual behavior (1 = Very Satisfied - 5 = Very Dissatisfied), the mean was 3.00 with one man (12.5%) reporting a 1, one (12.5%) reporting a 2, three (37.5%) reporting a 3, and three (37.5%) reporting a 4. On their satisfaction with their sexual thoughts (1 = Very Satisfied - 5 = Very Dissatisfied) the mean was 2.00 with three men (37.5%) reporting a 1, two (25%) reporting a 2, and three (37.5%) reporting a 3. On satisfaction with their sexual fantasies (1 = Very Satisfied - 5 = Very Dissatisfied) the mean was 2.125 with two men (25%) endorsing a 1, four (50%) endorsing a 2, one (12.5%) endorsing a 3, and one (12.5%) endorsing a 4.
All men endorsed prior homosexual experience with three men (37.5%) reporting occasional homosexual experience, two (25%) endorsing frequent homosexual behavior and three (37.5%) endorsing ongoing homosexual behavior. Four men (50%) endorsed putting themselves at risk for contracting a sexually transmitted disease in the past year. On the frequency of all sexual behavior (with or without a partner), one man (12.5%) endorsed having sexual behavior more than once a day, one (12.5%) reported having sexual behavior daily, and five (62.5%) reported engaging in sexual behavior more than once a week.

The Likert scale rating the severity of sexual abuse before age 15 (1 = Not at all - 5 = Severe) revealed a mean score of 1.625. Six men (75%) endorsed a 1, one (12.5%) endorsed a 3, and one (12.5%) reported a 4. Two men (25%) endorsed being sexually abused/molested as a child. One was eight years old and the other was nine years old when the abuse occurred. Both reported the abuse happened occasionally, one reporting the abuser was a person in authority and the other reporting the abuser was a friend.

The Likert scale rating the relationship with father in childhood (1 = Very Good - 5 = Very Poor) revealed a mean of 3.25 with three men (37.5%) reporting a 2, two (25%) reporting a 3, one (12.5%) reporting a 4, and two (25%) reporting a 5. The Likert scale rating the relationship with mother in childhood (1 = Very Good - 5 = Very Poor) revealed a mean of 1.375 with five men (62.5%) reporting a 1 and three (37.5%) endorsing a 2. The Likert scale rating the severity of physical abuse before age 15 (1 = Not at all - 5 = Severe) revealed a mean of one with all men endorsing a 1. The Likert scale rating the severity of emotional abuse before age 15 (1 = Not at all - 5 = Severe)
revealed a mean of 2.0 with three men (37.5%) endorsing a 1, three (37.5%) endorsing a 2, one (12.5%) endorsing a 3, and one (12.5%) reporting a 4. The Likert scale rating overall satisfaction with life (1 = Very Satisfied - 5 = Very Dissatisfied) revealed a mean of 2.125 with one man (12.5%) reporting a 1, five (62.5%) endorsing a 2, and two (25%) endorsing a 3.

Instruments

Demographic information requested included: age, socioeconomic status, education, ethnic background, sexual orientation, marriage history, marital status, counseling history, current medications, age of puberty, age when you first had sexual intercourse, and questions concerning sexual behavior (see Appendix C).

The State-Trait Anxiety Inventory or STAI (Spielberger, 1983) evaluates individual anxiety levels. Goldenson (1984) defines anxiety as a "pervasive feeling of dread, apprehension and impending disaster...a response to an undefined or unknown threat which in many cases stems from unconscious conflicts, feelings of insecurity, or forbidden impulses within ourselves" (p. 53). Spielberger (1983) breaks down anxiety into two constructs, state and trait anxiety. State anxiety is often described as an unpleasant emotional condition that is transitory. It refers to anxiety that can be experienced when evoked by the appropriate stimuli and may endure as long as stimulating conditions persist. State anxiety is characterized by feelings of tension, apprehension, nervousness, worry, and by activation or arousal of the autonomic nervous system. It is the forbidden impulses that make anxiety a factor to be studied in the area of compulsive behavior.
Trait anxiety refers to a relatively enduring feeling in which the person has a tendency to perceive the world as threatening and may react or behave in a specified manner (Spielberger, 1983). It refers to the differences between people in the tendency to perceive stressful situations as dangerous or threatening and the individual's response to environmental stressors with elevations in the intensity of their state anxiety reactions. Trait anxiety is described as how anxiety-prone an individual tends to be over time. It may also be an indicator of the individual differences in the frequency and intensity of past anxiety states and a predictor of how state anxiety will be experienced in the future. The stronger the anxiety trait, the more probable that the individual will experience more intense elevations in state anxiety in the future. Whether or not people who differ in trait anxiety will show corresponding differences in state anxiety depends on the extent to which each of them perceives a specific situation as psychologically dangerous or threatening. This is "greatly influenced by each individual's past experience" (p. 1).

The STAI is a 20 item paper-pencil inventory that assesses two aspects of anxiety: 1) state or current levels of anxiety and 2) trait or how anxiety prone the individual tends to be. Each item of the STAI is given a weighted score from one to four, one indicating "not at all," on a Likert scale and four indicating "very much so." The presence of a high level of anxiety is indicated by the rating of a four on ten S-Anxiety items and eleven T-Anxiety items (Spielberger, 1983). However, a rating of four on the remaining ten S-Anxiety items and the remaining nine T-Anxiety items indicates the absence of anxiety. Scores for both the S-Anxiety and T-Anxiety may vary from a minimum of 20 to a maximum of 80.
The construction of the STAI began in 1964 with the goal of developing a single set of items that could be administered with different instructions to provide objective measures of state and trait anxiety (Spielberger, 1983). In the construction and standardization of form Y, the more than 5,000 subjects tested showed a clear difference between state and trait anxiety. Additionally, testing showed that the anxiety-present and anxiety-absent factors were defined almost exclusively by S-Anxiety or T-Anxiety items.

Over 4,000 research studies using the STAI as a measure of anxiety have been listed (Spielberger, 1983b; Spielberger, 1985). The evidence of construct validity of the STAI has been shown on several populations. The STAI scores of military recruits in highly stressful training programs were shown to be higher than those of college and high school students of similar age in relatively nonstressful situations (Spielberger, 1983a). The mean S-Anxiety scores for the recruits were also significantly higher than their T-Anxiety scores, suggesting that they were experiencing a high state of emotional turmoil at the time of testing. In contrast, the college/high population's STAI mean S-Anxiety scores were not significantly different than the mean T-Anxiety scores (Spielberger, 1983a).

In a study of 71 undergraduates, Metzger (1976) examined the STAI's ability to accurately discriminate between the S-Anxiety and T-Anxiety scores. Subjects completed the STAI after an hour examination (stress condition) and in their class on a nonetest day (no-stress condition). Results indicated that the STAI was a highly reliable measure of stress and it discriminated well between high and low stress situations.

Some theorists have hypothesized that persons with compulsive sexual behavior have elevated levels of anxiety (Carnes, 1989; Earle & Crow, 1989; Goodman, 1993;
Wolf, 1988; Eber, 1981). However, there are few studies that have empirically validated this hypothesis. The study of anxiety seems salient in the area of compulsive sexual behavior because of the possible feelings of insecurity and the nature of the forbidden sexual impulses within the individual. Therefore, one might expect to see elevations in state and trait anxiety if the hypotheses are accurate.

The Sexual Addiction Screening Test or SAST (Carnes, 1989) is a 25 item paper-pencil test designed to assist in the assessment of sexually compulsive or "addictive" behavior (see Appendix D). The SAST provides a profile of responses to indicate differences between addictive and nonaddictive sexual behavior. A respondent answering 13 or more questions to the affirmative indicates that a person has compulsive sexual behavior.

The SAST was developed to identify the presence of sexually compulsive behavior. The "internal consistency of the instrument as measured by Cronbach's alpha for 191 male addicts was .92; for 67 nonaddict men was .85; and for 258 men in the total sample was .95" (Carnes, 1989, p. 216). He further states that 50 percent of the variance is in the individual's "desire to stop because of life unmanageability and powerlessness over sexual behavior...within that context the SAST can indicate the presence of addiction" (p. 217).

Of special note, there have been no norms for homosexual clients and the user is cautioned in the use of this instrument with the homosexual population. This is because homosexual men may have experiences and feelings in some ways parallel to those of
addicts in terms of shame and secrecy. Carnes (1989) states that more work needs to be done to establish validity of this instrument with homosexual men.

The Beck Depression Inventory (BDI) (Beck, Rush, Shaw, & Emery, 1979) is a widely accepted instrument which detects possible depression in normal populations (Steer, Beck, & Garrison, 1985) as well as psychiatric populations (Piotrowski, Sherry, & Keller, 1985). The BDI is a 21-item instrument that measures the presence and degree of depression in adolescents and adults. Each item of the BDI corresponds to a specific category of depressive symptoms or attitudes. The inventory is an easily administered pencil and paper test and is useful in mental health settings as a screening device for depression. The following guidelines are given in the BDI Manual (Beck & Steer, 1987) as ranges for scoring:

- **0-09** Normal Range or Asymptomatic
- **10-18** Mild/Moderate Depression
- **19-29** Moderate/Severe Depression
- **30-63** Extremely Severe Depression

Depression as defined by Beck (1987) is a negative view of the self, the world, and the future, along with self-blame and criticism. He presented a list of 21 symptom-attitude categories. The BDI's items represent each of the following categories: mood, pessimism, sense of failure, lack of satisfaction, guilt feelings, sense of punishment, self-dislike, self-accusation, suicidal wishes, crying, irritability, social withdrawal, indecisiveness, distortion of body image, work inhibition, sleep disturbance, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido.
The BDI is the most widely used self-report measure of depression in English (Robinson, Shaver, & Wrightsman, 1991) and has been employed in over 1,000 different research studies (Beck, Steer, & Garbin, 1988). The internal consistency of the BDI within 15 non-psychiatric samples measured a mean alpha of 0.81; the range was from 0.73 to 0.92 (Beck, Steer, & Garbin, 1988). In his 1967 book, Beck reported an odd-even split-half reliability coefficient of .86 (with a Spearman-Brown correction of .93). This indicates that the BDI is a highly reliable measure of depression.

The content validity of the BDI compares favorably with the DSM-III criteria for depression, reflecting six of the nine criteria well and two of the nine only partially (Beck, Steer, & Garbin, 1988). The only discrepancies is the BDI asks only about losses of appetite but does not ask about increases in appetite and asks about disturbances in sleep but not sleeping more than usual. Therefore, the BDI content correlates well with the DSM-III criteria.

There are many studies that have indicated that the BDI is a useful tool in differentiating depression in psychiatric patients from normals (Akiskal, Lemni, Yerevanian, King, & Belluomini, 1982; Byerly & Carlson, 1982; Gallagher, Nies, & Thompson, 1982). Additionally, the BDI is consistently and significantly related to a clinical rating of depression and to the biological, electrophysiological, psychosocial, and cross-cultural manifestations and correlates of depression (Robinson, Shaver, & Wrightsman, 1991). For the reason, the authors state that the BDI is often used by other "scale developers to validate new measures so almost by definition it is highly related to
other measures" (p. 202). Therefore, validity information indicates that the BDI is a valid measure of depression.

Several theorists (Goodman, 1981; Levine, 1982; Werner, 1989) have hypothesized that depression is present in persons with compulsive sexual behavior. However, there is little empirical research that shows depression to be a factor in compulsive sexual behavior. The study of depression in this population seems relevant. Specifically, the depression symptoms of interest are hopelessness, helplessness, loss of control, sense of failure, guilt, self-dissatisfaction, self-dislike, self-accusations, social withdrawal, punishment, and somatic preoccupation.

The Coopersmith Self-Esteem Inventory (Coopersmith, 1981) was used to measure self-esteem. The CSE is an easily scored 25-item instrument that measures self-evaluative attitudes that one holds concerning social, academic, family, and personal expectations. Coopersmith defined self-esteem as the "evaluation of self and indicates the extent to which an individual believes himself to be capable, significant, successful, and worthy" (Coopersmith, 1967, p. 4-5). Additionally, he states that:

the term "self-esteem" refers to the evaluation a person makes and customarily maintains with regard to him- or herself...expresses an attitude of approval or disapproval and indicates the extent to which a person believes him-herself as capable, significant, successful, and worthy. In short, a person's self-esteem is a judgement of worthiness that is expressed by the attitudes he or she holds toward the self. It is a subjective experience conveyed to others by verbal reports and other overt expressive behavior. (Coopersmith, 1981, p. 5)
The CSE measures self-esteem as an expression of approval or disapproval, which indicates the extent to which a person perceives himself as successful, competent, and worthy. It is among the most widely utilized of the self-esteem inventories (Peterson & Austin, 1985).

Chiu (1985) found that the CSE had a test-retest reliability coefficients ranging from .72 to .85 for students over a two month period. This indicates a relatively high test-retest reliability. The data also indicated evidence for concurrent validity with teacher's popularity ratings, teacher's self-esteem rating of the student and with student's popularity ratings. Other research has found similar findings showing validity (Cress & O'Donnell, 1975; Spatz & Johnson, 1973; Watkins & Astila, 1980).

Procedure

Subjects were asked to voluntarily participate in a study about sexual behavior and personality traits. After initial screening, the testing consisted of self-administered pencil and paper tests. Each subject was given a packet consisting of a cover letter, consent form, demographic questionnaire, State-Trait Anxiety Inventory, Beck Depression Inventory, Coopersmith Self-Esteem Inventory, Sexual Addiction Screening Test, and Sexual Behavior Survey of present sexual behavior. Participants received pre-addressed and stamped envelopes to return their consent forms separately from their measures. This ensured confidentiality and anonymity.

Research Design

Mean group scores of the STAI, BDI, CSE and the SAST were calculated for each group and significant differences were evaluated using one-way multivariate analysis.
of variance (MANOVA) and followed by post hoc tests. The levels are: homosexual sexual compulsives, heterosexual sexual compulsives, homosexual noncompulsives and heterosexual noncompulsives. The .05 level of significance was used to reject the null hypothesis.

Research Questions

This study explored four research questions. This first question was: Do men who have a history of sexually compulsive behavior exhibit more symptoms of depression than men who report no history of sexually compulsive behavior? The second question was: Do men who exhibit a history of compulsive sexual behavior have lower perceptions of themselves than men without a history of compulsive sexual behavior? The third question was: Do men who exhibit a history of compulsive sexual behavior have more trait (characterological) anxiety than men without a history of compulsive sexual behavior? The final question was: Do men who exhibit a history of compulsive sexual behavior exhibit more state (situational) anxiety than men without a history of compulsive sexual behavior?

Results of this study hypothesized that:

1. There is no significant difference in depression measures between men who do not report sexually compulsive behavior and men with compulsive sexual behavior.

2. There is no significant difference in self-esteem measures between men who do not report sexually compulsive behavior and men with compulsive sexual behavior.

3. There is no significant difference in trait anxiety measures between men who do not report sexually compulsive behavior and men with compulsive sexual behavior.
4. There is no significant difference in state anxiety measures between men who do not report sexually compulsive behavior and men with compulsive sexual behavior.
CHAPTER 3

RESULTS

The current study examined the personality characteristics of sexually compulsive heterosexual and homosexual men. They were compared to noncompulsive heterosexual and homosexual men in their levels of depression, state anxiety, trait anxiety, and self-esteem. The means and standard deviations for the BDI, STAI, and CSE are presented in Table 2 (Appendix E).

Multivariate analysis of variance (MANOVA) and univariate analysis of variance (ANOVA) were performed. For ANOVA, a multiple comparison adjustment (Bonferroni adjustment) was used. Bonferroni adjustments were used to control for Type I error rates for multiple ANOVA's. Results are presented in Tables 3, 4, and 5 (Appendix E).

One way MANOVA was performed on four dependent variables: depression, state anxiety, trait anxiety, and self-esteem. The independent variable was the presence of sexual compulsive behavior (SAST Total Score >13). SPSS MANOVA was used for the analysis. There was a total N of 87 with no cases missing. There were no univariate or multivariate within cell outliers at \( p < .001 \). Results of the evaluation of assumptions of normality, homogeneity of variance-covariance matrices, linearity and multicollinearity were satisfactory.

With the use of Wilk's criterion, the combined DVs were significantly affected by presence of sexually compulsive behavior, \( F (12, 211.95) = 6.075, \ p < .001 \). The partial
eta squared was .23 with the power (one minus Type II error) equal to 1.00. This reflects a large degree of association between the combined DV's and sexual compulsive behavior.

To investigate the impact of the main effect on each DV, a Roy-Bargmann stepdown analysis was performed on the prioritized DVs. In the stepdown analysis, each DV was analyzed respectively, with the high priority DV treated as covariates and with the highest priority DV tested in a univariate ANOVA.

The unique contribution to predicting differences between depression (BDITOTAL) on the presence of sexual compulsive behavior, stepdown $F (3, 83) = 19.95, p < .001$, partial eta equal .41902 with power equal to 1.00. With differences due to depression (BDI) already entered, self esteem (CITOT) made a unique contribution toward explaining differences in presence of sexually compulsive behavior, step $F (3, 82) = 4.6687, p = .005$, partial eta equal .44077 with power equal 1.00. An ANOVA indicated that state anxiety was significant $F (3, 83) = 22.7199, p < .001$ with partial eta equal .45091 with power equal to 1.00. However, this difference was already represented in the stepdown analysis (ANCOVA) by the higher priority DVs, which resulted in a statistically nonsignificant stepdown $F$ for state anxiety (STAI1TOT), stepdown $F (3, 81) = .147$. Trait anxiety (STAI2TOT) was not statistically significant in either the univariate ANOVA or the stepdown $F$ test (ANCOVA). The pooled within-cell correlations among DVs are shown in Tables 6-9.

Additionally ANOVA's were performed on each DV with the corresponding post hoc tests (Tukey-HSD). These results are presented in Tables 3-5. Correlation coefficients were run on each of the dependent variables. Table 6 shows the correlation
coefficients for the dependent variable for heterosexual sexual compulsive men. Table 7 shows the correlation coefficients for the homosexual sexual compulsive men. Table 8 shows the correlation coefficients for the heterosexual noncompulsive men. Table 9 shows the correlation coefficients for the homosexual noncompulsive men.
CHAPTER 4

DISCUSSION

The current study examined the personality characteristics of sexually compulsive heterosexual and homosexual men. They were compared to noncompulsive men of their same sexual orientation on their levels of depression, state anxiety, trait anxiety, and self-esteem.

The first hypothesis examined the difference in levels of depression between sexually compulsive men and noncompulsive men. The current study found sexually compulsive groups scoring significantly higher on depression than their noncompulsive groups. The depression level of sexually compulsive homosexual men was significantly higher than sexually compulsive heterosexual men. Sexually compulsive homosexual men reported a mean score indicating moderate/severe depression. The sexually compulsive heterosexual men reported a mean score indicating mild/moderate depression. Both of the noncompulsive groups scores in the normal/asymptomatic range of depression.

These results indicate the sexually compulsive individual may be moderately depressed and may use sexual behavior as a coping skill to deal with the depression. In this light, the compulsive individual "medicates" himself with sex in order to feel better and cope with significant distress. This supports Wolf's (1988) theory in which the sexually compulsive individual has a historical pattern of depressive ideation in response to stress.
These results may also indicate the sexually compulsive individual experiences emotional distress as a response to his sexual behavior. His sexual behavior may begin the process of depression, causing the person to feel hopeless and helpless, powerless and despair because the behavior is perceived to be out of his conscious control. This possibility supports Carnes (1983, 1986) theory in which the addict feels isolated and lonely and can only relieve the negative emotional feelings by focusing on returning to the sexual compulsive behavior.

The second hypothesis examined the difference in state anxiety between sexually compulsive men and noncompulsive men. The results of the current study showed the sexually compulsive groups scored significantly higher on state anxiety measures than their noncompulsive counterparts. The noncompulsive groups had few symptoms of anxiety whereas the sexually compulsive groups experienced moderate levels of anxiety.

This supports Earle and Crow's (1989) and Schwartz and Brasted's (1985) theories that compulsions result from a person's need to relieve stress or escape from unpleasant feelings. This indicates sexually compulsive individuals may lack healthy stress coping skills to handle situational stress. If the sexual compulsive individual copes with situational stress by being sexual, the situational stressor is unlikely to be resolved. The individual may feel temporary relief that comes from not focusing on a problem, but will most likely not feel a reduction in his overall stress level.

Coupled with the moderate levels of depression evidenced in this sample of sexually compulsive men, each person may not think he can overcome situational problems which increase his response to a stressful event. Thus, when situational stressors
continue unresolved, the feelings of hopelessness, helplessness and despair may exacerbate
the anxiety response to future stressors. The depression and lack of stress coping to
situational stressors may likely cause the individual to feel constantly overwhelmed and
unable to cope.

The third hypothesis examined the difference in trait anxiety between sexually
compulsive men and noncompulsive men. The results of the current study showed no
significant difference between sexually compulsive groups and noncompulsive groups.
This indicates the frequency of characterological anxiety is similar among all groups.

The finding that state (situational) anxiety is significantly higher in sexually
compulsive men but trait (characterological) anxiety shows no significant difference may
have treatment implications. It may be necessary to address the person's response to
situational stress early in treatment. Teaching stress coping skills (deep breathing,
relaxation, biofeedback) and problem solving strategies (negotiation, communication
skills, breaking down problems into micro-solutions) may be crucial in helping the person
achieve long-term success. Focusing on characterological issues (long-term fears,
personality characteristics, inability to trust) early in treatment may not address this
population's most pressing need, learning how to cope effectively with situational
stressors.

The final hypothesis examined the difference in self-esteem measures between
sexually compulsive men and noncompulsive men. The current study showed the sexually
compulsive groups scored significantly lower on self-esteem measures than their
noncompulsive counterparts. Another interesting finding indicated the self-esteem of
sexually compulsive homosexual men was significantly lower than sexually compulsive heterosexual men.

There are two possible reasons how self-esteem is a factor. First, the present study supports Wolf's (1988) theory that low self esteem is a factor in sexual compulsive behavior. He postulates low self image is the starting point for the addiction, causing depression or dissatisfaction in his life situation. However, this study cannot determine if the individual exhibited low self-esteem before the compulsive sexual began or whether the low self-esteem is a by-product of acting out sexual behavior that is counter to the individual's values and morals.

A second possibility for the significantly lower self esteem scores for sexually compulsive men may be that compulsive sexual behavior distorts an individual's ability to accurately evaluate himself which comes as a result of exhibiting compulsive sexual behavior. Instead of having the foundational low self esteem that may produce compulsive sexual behavior, the individual is merely reacting to acting outside what he thinks is acceptable behavior. Any behavior outside what the person deems right or value congruent may cause the person to negatively evaluate himself or feel shame. Shame is a common emotional state among sexually compulsive individuals (Carnes, 1986).

This could also explain why the homosexual sexual compulsive's scores are significantly lower than heterosexual sexual compulsives. It is possible they consider their behavior to be more deviant from the established sexual norm. Thus, their self esteem would be judged by themselves to be lower. Another possible explanation could be the internalization of negative messages about homosexuality in our society.
Limitations

Although this study yielded interesting results, it is not without limitations. First, approximately 94% of this sample was White; the findings need to be borne out in a more ethnically diverse sample. Second, this study was restricted to men between the ages of 27-40 years. A study needs to be conducted with younger men and older men to see if it might yield different results. Third, because the SAST has not been normed on homosexual men with compulsive behavior, it would be necessary to use a screening test that has been normed on this population. Fourth, caution should be used with generalizations, because although the researched variables bore significant differences, they may not be significant for individuals in treatment but rather may help the clinician be aware of issues prevalent for a significant number of men dealing with the issue of sexual compulsive behavior. The value of these results for researchers or counselors is that they should take into account the individual's unique characteristics and test each individual for results that may be similar to the present study. Fifth, the participants in the current study were heavily Protestant (85%), it would be interesting to have a sample that was more religiously diverse. Finally, data were gathered through the use of self-report measures that were not administered in random order. The order of how the tests were taken could possibly affect the subject's answers on subsequent measures and giving them in random order might control for that factor.

Beyond demographic limitations, this research cannot indicate whether the studied characteristics existed before the compulsive sexual behavior or whether the sexually compulsive behavior caused the studied characteristics. Understanding the impact of
sexually compulsive behavior on an individual would be as interesting and important as knowing the underlying personality characteristics causing sexually compulsive behavior. No conclusions about causation can be drawn from this study.

**Future Research**

These limitations suggest the need for future researchers to investigate the personality characteristics of men dealing with compulsive sexual behavior. The current study examined four personality characteristics of sexually compulsive homo- and heterosexual men compared to homo- and heterosexual noncompulsives. The characteristics this study examined indicate a pattern of internalization of stress or a pattern of coping by using sexual behavior. Unfortunately, the consequences of using sexual behavior may be lowered self-esteem and depression. Future research in this area may include examining these characteristics, and others, using a much larger samples. It would also be interesting to examine coping skills, locus of control, Axis II disorders, state and trait anger, anger expression, mood disorders and methods of treatment for sexually compulsive men. There are indications from observations these individuals may have problems coping and being in relationships. Further research may help identify specific issues to help determine what avenues can be taken to help in the definition, treatment, and prevention of sexually compulsive behavior.
APPENDIX A

DIAGNOSTIC CRITERIA FOR ADDICTION
Diagnostic Criteria for Addiction

Addiction

A. Recurrent failure to resist impulses to engage in a specified behavior.

B. Increasing sense of tension immediately prior to initiating the behavior.

C. Pleasure or relief at the time of engaging in the behavior.

D. At least five of the following:

1) frequent preoccupation with the behavior or with activity that is preparatory to the behavior

2) frequent engaging in the behavior to a greater extent or over a longer period of time than intended

3) repeated efforts to reduce, control or stop the behavior

4) a great deal of time spent in activities necessary for the behavior, engaging in the behavior, or recovering from its effects

5) frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations

6) important social, occupational or recreational activities given up or reduced because of the behavior

7) continuation of the behavior despite the knowledge of having a persistent or recurrent social, financial, psychological or physical problem that is caused or exacerbated by the behavior
8) tolerance: need to increase the intensity or frequency of the behavior in order

to achieve the desired effect or diminished effect with continued behavior

of the same intensity

9) restlessness or irritability if unable to engage in the behavior

E. Some symptoms of the disturbance have persisted for at least one month, or have

occurred repeatedly over a longer period of time.
APPENDIX B

DIAGNOSTIC CRITERIA FOR SEXUAL ADDICTION
Diagnostic Criteria For Sexual Addiction

A. Recurrent failure to resist impulses to engage in a specified sexual behavior.

B. Increasing sense of tension immediately prior to initiating the sexual behavior.

C. Pleasure or relief at the time of engaging in the sexual behavior.

D. At least five of the following:

1) Frequent preoccupation with the sexual behavior or with activity that is preparatory to the sexual behavior

2) Frequent engaging in the sexual behavior to a greater extent or over a longer period than intended

3) repeated efforts to reduce, control, or stop the sexual behavior

4) a great deal of time spent in activities necessary for the sexual behavior, engaging in the sexual behavior, or recovering from its effects

5) frequent engaging in the sexual behavior when expected to fulfill occupational, academic, domestic, or social obligations

6) important social, occupational, or recreational activities given up or reduced because of the sexual behavior

7) continuation of the sexual behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the sexual behavior
8) tolerance: need to increase the intensity or frequency of the sexual behavior in order to achieve the desired effect, or diminished effect with continued sexual behavior of the same intensity

9) restlessness or irritability if unable to engage in the sexual behavior

E. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
DEMOGRAPHIC QUESTIONNAIRE

Please list or circle the response that is correct for you. Please answer every question.

1. Age____

2. Marital status now: Single ___ Married ___ Divorced ___ Widowed ___
   (a) If married or divorced, number of times married (current marriage included): _______
   (b) If married, length of time of present marriage ______

3. Circle the highest level of education completed:
   (a) Jr High School or less         (c) High school graduate or GED equivalent
   (b) College graduate            (d) Completed a graduate degree

4. State your approximate yearly net income. ____________

5. Race
   (a) Caucasian         (c) African American      (e) American Indian
   (b) Hispanic          (d) Asian                  (f) Other (specify) ______________

6. How would you describe your current sexual behavior (circle one)?
   (a) Exclusively homosexual
   (b) More homosexual than heterosexual
   (c) Equally homosexual and heterosexual
   (d) More heterosexual than homosexual
   (e) Exclusively heterosexual

7. Are you satisfied with what you circled on question 6? YES NO

8. How would you describe your current sexual orientation?
   (a) Exclusively homosexual
   (b) More homosexual than heterosexual
   (c) Equally homosexual and heterosexual
   (d) More heterosexual than homosexual
   (e) Exclusively heterosexual

9. Are you satisfied with what you circled on question 8 (Circle one)? YES NO
10. Are you currently in a committed relationship? YES NO
   (a) If yes, on a scale of 1 to 5, how satisfied are you with that relationship?
      1  2  3  4  5
      (Dissatisfied) (Satisfied)

11. What is your current level of satisfaction with your sexual life?
    Sexual Behavior  1  2  3  4  5
    Sexual Thoughts  1  2  3  4  5
    Sexual Fantasies 1  2  3  4  5
    (Very Satisfied) (Very Dissatisfied)

12. How often do you attend religious services?
    (a) Never
    (b) Less than once a week
    (c) More than once a week

13. How important is religion or spirituality in your life?
    (a) Very important
    (b) Somewhat important
    (c) Not important

14. Religion
    (a) Catholic
    (b) Protestant
    (c) Mormon
    (d) Jewish
    (e) None
    (f) Other (Please specify) ________________________________

15. On a scale of 1 to 5, how religious would you rate yourself?
    1  2  3  4  5
    (Not religious) (Very religious)

16. Have you had any homosexual experience? YES NO
    If yes, then please circle one: Once Occasionally Frequently Ongoing
17. I put myself at risk to contract a sexually transmitted disease in the last year:  YES  NO

18. Frequency of all sexual activity (with or without a partner) is (Circle the one that best represents your overall behavior pattern):
   (a) More than once a day  (b) Daily  (c) 2-5 times a week
   (d) Weekly  (e) Monthly  (f) Rarely

19. How many sessions have you attended a recovery group dealing with sexual compulsive behavior or other sexual behavior that is against your values? ______

20. How many sessions have you attended individual counseling dealing with sexual compulsive behavior or other sexual behavior that is against your values? ______

21. The relationship with my father or father-figure in my childhood was:
   1 2 3 4 5
   (Very Good) (Very Poor)

22. The relationship with my mother or mother-figure in my childhood was:
   1 2 3 4 5
   (Very Good) (Very Poor)

23. I was sexually molested/abused as a child:  YES  NO
   (a) If yes, what was your age ______
   (b) The frequency of the abuse was (Circle one): Once Occasionally Often Ongoing
   (c) If yes, who was the molester: Adult stranger Relative Person in Authority

24. On the following scale, rate the severity of physical abuse before age 15:
   1 2 3 4 5
   (Not at all) (Severe)

25. On the following scale, rate the severity of emotional abuse (e.g., yelling) before age 15:
   1 2 3 4 5
   (Not at all) (Severe)

26. On the following scale, rate the severity of sexual abuse as a child:
   1 2 3 4 5
   (Not at all) (Severe)

27. On a scale of one to five, what is your current overall satisfaction with your life?
   1 2 3 4 5
   (Very Satisfied) (Very Dissatisfied)
APPENDIX D

THE SEXUAL ADDICTION SCREENING TEST
The Sexual Addiction Screening Test

To complete this test, answer each question by placing a check in the appropriate yes no column.

YES  NO
1. Were you sexually abused as a child or adolescent?
2. Have you subscribed or regularly purchased sexually explicit magazines like Playboy or Penthouse?
3. Did your parents have trouble with sexual behavior?
4. Do you often find yourself preoccupied with sexual thoughts?
5. Do you feel that your sexual behavior is not normal?
6. Does your spouse [or significant other(s)] ever worry or complain about your sexual behavior?
7. Do you have trouble stopping your sexual behavior when you know it is inappropriate?
8. Do you ever feel bad about your sexual behavior?
9. Has your sexual behavior ever created problems for you or your family?
10. Have you ever sought help for sexual behavior you did not like?
11. Have you ever worried about people finding out about your sexual activities?
12. Has anyone been hurt emotionally because of your sexual behavior?
13. Are any of your sexual activities against the law?
14. Have you made promises to yourself to quit some aspect of your sexual behavior?
15. Have you made efforts to quit a type of sexual activity and failed?
16. Do you have to hide some parts of your sexual activity?
17. Have you attempted to stop some parts of your sexual activity?
18. Have you ever felt degraded by your sexual behavior?
19. Has sex been a way for you to escape your problems?
20. When you have sex, do you feel depressed afterwards?
21. Have you felt the need to discontinue a certain form of sexual activity?
22. Has your sexual activity interfered with your family life?
23. Have you been sexual with minors?
24. Do you feel controlled by your sexual desire?
25. Do you ever think your sexual desire is stronger than you are?

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APPENDIX E

TABLES
Table 1
Summary of Participant's Demographics by Group

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HetCom</td>
<td>HomCom</td>
<td>HetNon</td>
<td>HomNon</td>
</tr>
<tr>
<td></td>
<td>(N = 22)</td>
<td>(N = 19)</td>
<td>(N = 38)</td>
<td>(N = 8)</td>
</tr>
<tr>
<td>Mean Age</td>
<td>31.95</td>
<td>33.26</td>
<td>34.42</td>
<td>32.25</td>
</tr>
<tr>
<td>Mean Income</td>
<td>$35,818</td>
<td>$43,342</td>
<td>$57,342</td>
<td>$31,000</td>
</tr>
<tr>
<td>Marital Status - Married</td>
<td>72.7% (16)</td>
<td>26.3% (5)</td>
<td>89.5% (34)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Single</td>
<td>22.7% (5)</td>
<td>63.2% (12)</td>
<td>7.9% (3)</td>
<td>87.5% (7)</td>
</tr>
<tr>
<td>Divorced</td>
<td>4.5% (1)</td>
<td>10.3% (2)</td>
<td>2.6% (1)</td>
<td></td>
</tr>
<tr>
<td>Education - High School Graduate</td>
<td>40.9% (9)</td>
<td>15.8% (4)</td>
<td>13.2% (5)</td>
<td>50% (4)</td>
</tr>
<tr>
<td>College Graduate</td>
<td>40.9% (9)</td>
<td>63.2% (12)</td>
<td>65.8% (25)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Complete Graduate Degree</td>
<td>18.2% (4)</td>
<td>15.8% (3)</td>
<td>21.1% (8)</td>
<td>37.2% (3)</td>
</tr>
<tr>
<td>Race - Caucasian</td>
<td>86.4% (19)</td>
<td>89.5% (17)</td>
<td>100% (38)</td>
<td>100% (8)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.5% (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>9.1% (2)</td>
<td>10.3% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Sexual Behavior</td>
<td>72.7% (16)</td>
<td>52.6% (10)</td>
<td>100% (38)</td>
<td>100% (8)</td>
</tr>
<tr>
<td>Satisfaction with Sexual Orientation</td>
<td>77.3% (17)</td>
<td>52.6% (10)</td>
<td>100% (38)</td>
<td>100% (8)</td>
</tr>
<tr>
<td>Involved in Committed Relationship</td>
<td>77.3% (17)</td>
<td>47.4% (9)</td>
<td>97.4% (37)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Religious Preference - Protestant</td>
<td>95.5% (21)</td>
<td>68.4% (13)</td>
<td>92.1% (35)</td>
<td>62.5% (3)</td>
</tr>
<tr>
<td>No Preference</td>
<td>4.5% (1)</td>
<td>21.1% (4)</td>
<td></td>
<td>25% (2)</td>
</tr>
<tr>
<td>Jewish</td>
<td></td>
<td>5.3% (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td></td>
<td></td>
<td>7.9% (3)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of Attendance of Religious Services - Never</td>
<td>4.5% (1)</td>
<td>26.3% (5)</td>
<td></td>
<td>25% (2)</td>
</tr>
<tr>
<td>More than once a week</td>
<td>63.6% (14)</td>
<td>47.4% (9)</td>
<td>81.6% (31)</td>
<td>75% (6)</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>31.8% (7)</td>
<td>26.3% (5)</td>
<td>18.4% (7)</td>
<td></td>
</tr>
<tr>
<td>Mean Importance of Spirituality</td>
<td>81.8% (18)</td>
<td>52.6% (10)</td>
<td>97.4% (37)</td>
<td>75% (6)</td>
</tr>
<tr>
<td>Very</td>
<td>13.6% (3)</td>
<td>26.3% (5)</td>
<td>2.6% (1)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Somewhat</td>
<td>4.5% (1)</td>
<td>21.1% (4)</td>
<td></td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Religiosity</td>
<td>3.445</td>
<td>3.263</td>
<td>4.363</td>
<td>3.635</td>
</tr>
<tr>
<td>Mean Satisfaction with sexual:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>3.455</td>
<td>3.579</td>
<td>2.289</td>
<td>3.00</td>
</tr>
<tr>
<td>Thoughts</td>
<td>3.364</td>
<td>3.789</td>
<td>2.211</td>
<td>2.00</td>
</tr>
<tr>
<td>Fantasies</td>
<td>3.22</td>
<td>3.632</td>
<td>2.263</td>
<td>2.125</td>
</tr>
<tr>
<td>Ever had homosexual experience</td>
<td>54.5%</td>
<td>100%</td>
<td>15.8% (6)</td>
<td>100% (8)</td>
</tr>
<tr>
<td>Put self at risk for sexually transmitted disease in the past year</td>
<td>40.9% (9)</td>
<td>94.7% (18)</td>
<td>2.6% (1)</td>
<td>50% (4)</td>
</tr>
<tr>
<td>Frequency of sexual behavior:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than once a day</td>
<td>18.2% (4)</td>
<td>36.8% (7)</td>
<td>2.6% (1)</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>9.1% (2)</td>
<td>21.3% (4)</td>
<td>2.6% (1)</td>
<td>25% (2)</td>
</tr>
<tr>
<td>2-5 times weekly</td>
<td>59.4% (11)</td>
<td>21.1% (4)</td>
<td>44.7% (17)</td>
<td>62.5% (5)</td>
</tr>
<tr>
<td>Weekly</td>
<td>13.6% (3)</td>
<td>10.5% (2)</td>
<td>39.5% (15)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Monthly</td>
<td>9.1% (2)</td>
<td></td>
<td>7.9% (3)</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
<td>5.3% (1)</td>
<td>2.6% (1)</td>
<td></td>
</tr>
<tr>
<td>Mean severity of sexual abuse before age 15</td>
<td>1.682</td>
<td>2.421</td>
<td>1.079</td>
<td>1.625</td>
</tr>
<tr>
<td>Reported sexual abuse/attempted</td>
<td>36.4% (8)</td>
<td>57.9% (11)</td>
<td>2.6% (1)</td>
<td>25% (2)</td>
</tr>
<tr>
<td>Mean relationship with father</td>
<td>3.227</td>
<td>4.368</td>
<td>1.974</td>
<td>3.25</td>
</tr>
<tr>
<td>Mean relationship with mother</td>
<td>2.636</td>
<td>2.947</td>
<td>1.632</td>
<td>1.375</td>
</tr>
<tr>
<td>Mean severity of physical abuse</td>
<td>2.277</td>
<td>2.6</td>
<td>1.132</td>
<td>1.00</td>
</tr>
<tr>
<td>Mean severity of emotional abuse</td>
<td>2.545</td>
<td>2.947</td>
<td>1.5</td>
<td>2.00</td>
</tr>
<tr>
<td>Mean overall satisfaction with life</td>
<td>2.909</td>
<td>3.474</td>
<td>1.974</td>
<td>2.125</td>
</tr>
</tbody>
</table>

Table 2

Means and Standard Deviations for the BDI, STAI, and the CI

<table>
<thead>
<tr>
<th>Scale</th>
<th>HetCom (n = 22)</th>
<th>HomCom (n = 19)</th>
<th>HetNon (n = 38)</th>
<th>HomNon (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>BDI</td>
<td>14.86</td>
<td>12.49</td>
<td>23.15</td>
<td>11.77</td>
</tr>
<tr>
<td>SA</td>
<td>44.18</td>
<td>12.75</td>
<td>58.47</td>
<td>14.25</td>
</tr>
<tr>
<td>TA</td>
<td>50.90</td>
<td>28.52</td>
<td>48.31</td>
<td>27.73</td>
</tr>
<tr>
<td>CI</td>
<td>60.36</td>
<td>21.52</td>
<td>39.57</td>
<td>24.97</td>
</tr>
</tbody>
</table>

Note. HetCom = Heterosexual Compulsive; HomCom = Homosexual Compulsive; HetNon = Heterosexual Noncompulsive; HomNon = Homosexual Noncompulsive; BDI = Beck Depression Inventory; SA = State Trait Anxiety Inventory - State Anxiety; TA = State Trait Anxiety Inventory - Trait Anxiety; CI = Coopersmith Inventory.
### Table 3

**Analysis of Variance of the BDI Between Groups**

<table>
<thead>
<tr>
<th>Mean</th>
<th>GROUP</th>
<th>HetNon</th>
<th>HomNon</th>
<th>HetCom</th>
<th>HomCom</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7895</td>
<td>HetNon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1250</td>
<td>HomNon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.8636</td>
<td>HetCom</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.1579</td>
<td>HomCom</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

(*) Indicates significant differences $p < .001$

**Note:** HetCom = Heterosexual Compulsives; HomCom = Homosexual Compulsives; HetNon = Heterosexual Noncompulsives; HomNon = Homosexual Noncompulsives
Table 4

**Analysis of Variance of the Coopersmith Inventory Between Groups**

<table>
<thead>
<tr>
<th>Mean</th>
<th>Group</th>
<th>HomCom</th>
<th>HetCom</th>
<th>HetNon</th>
<th>HomNon</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.5789</td>
<td>HomCom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60.3636</td>
<td>HetCom</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82.4211</td>
<td>HetNon</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86.0000</td>
<td>HomNon</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .001

**Note.** HomCom = Homosexual Compulsive; HetCom = Heterosexual Compulsive; HetNon = Heterosexual Noncompulsive; HomNon = Homosexual Noncompulsive.
Table 5

Analysis of Variance of the STAI (State Anxiety) Between Groups

<table>
<thead>
<tr>
<th>Mean</th>
<th>GROUP</th>
<th>HetNon</th>
<th>HomNon</th>
<th>HetCom</th>
<th>HomCom</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.8947</td>
<td>HetNon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.8750</td>
<td>HomCom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44.1818</td>
<td>HetCom</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58.4737</td>
<td>HomNon</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

*p < .001

Note: HomCom = Homosexual Compulsive; Het Com = Heterosexual Compulsive; HetNon = Heterosexual Noncompulsive; HomNon = Homosexual Noncompulsive.
Table 6

Correlation Coefficients of Dependent Variables for Heterosexual Sexual Compulsives

<table>
<thead>
<tr>
<th></th>
<th>BDI</th>
<th>CI</th>
<th>STAI (State)</th>
<th>STAI (Trait)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>-.4214</td>
<td>.4393</td>
<td>.2576</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 22)</td>
<td>( 22)</td>
<td>( 22)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = .051</td>
<td>p = .041</td>
<td>p = .247</td>
<td></td>
</tr>
<tr>
<td>CI</td>
<td>-0.4035</td>
<td>.0336</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 22)</td>
<td>( 22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = .063</td>
<td>p = .882</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (State)</td>
<td></td>
<td></td>
<td>.3426</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 22)</td>
<td></td>
<td>( 22)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = .119</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (Trait)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. BDI = Beck Depression Inventory; SA = State Trait Anxiety Inventory-State Anxiety; TA = State Trait Anxiety Inventory - Trait Anxiety; CI = Coopersmith Inventory.
Table 7

Correlation Coefficients of Dependent Variables for Homosexual Sexual Compulsives

<table>
<thead>
<tr>
<th></th>
<th>BDI</th>
<th>CI</th>
<th>STAI (State)</th>
<th>STAI (Trait)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>-.6737</td>
<td>.7685</td>
<td>.1727</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 19)</td>
<td>( 19)</td>
<td>( 19)</td>
<td></td>
</tr>
<tr>
<td>p</td>
<td>.002</td>
<td>.000</td>
<td>.480</td>
<td></td>
</tr>
<tr>
<td>CI</td>
<td>-.5523</td>
<td>-.0081</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 19)</td>
<td>( 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p</td>
<td>.014</td>
<td>.974</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (State)</td>
<td>.1256</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 19)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p</td>
<td>.068</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (Trait)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. BDI = Beck Depression Inventory; SA = State Trait Anxiety Inventory - State Anxiety; TA = State Trait Anxiety Inventory - Trait Anxiety; CI = Coopersmith Inventory.
Table 8

Correlation Coefficients of Dependent Variables for Heterosexual Non-Compulsives

<table>
<thead>
<tr>
<th></th>
<th>BDI</th>
<th>CI</th>
<th>STAI (State)</th>
<th>STAI (Trait)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>-0.6069</td>
<td>0.5880</td>
<td>-0.0416</td>
<td></td>
</tr>
<tr>
<td>(38)</td>
<td>(38)</td>
<td>(38)</td>
<td>(38)</td>
<td></td>
</tr>
<tr>
<td>p = .000</td>
<td>p = .000</td>
<td>p = .804</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CI</td>
<td>-0.6609</td>
<td>0.0959</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(38)</td>
<td>(38)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p = .000</td>
<td>p = .567</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (State)</td>
<td></td>
<td></td>
<td>-0.0401</td>
<td></td>
</tr>
<tr>
<td>(38)</td>
<td></td>
<td></td>
<td>(38)</td>
<td></td>
</tr>
<tr>
<td>p = .811</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (Trait)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. BDI = Beck Depression Inventory; SA = State Trait Anxiety Inventory - State Anxiety; TA = State Trait Anxiety Inventory - Trait Anxiety; CI = Coopersmith Inventory.
Table 9

Correlation Coefficients of Dependent Variables for Homosexual Non-Compulsives

<table>
<thead>
<tr>
<th></th>
<th>BDI</th>
<th>CI</th>
<th>STAI (State)</th>
<th>STAI(Trait)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>- .2218</td>
<td>.5866</td>
<td>-.3796</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 8)</td>
<td>( 8)</td>
<td>( 8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = .598</td>
<td>p = .126</td>
<td>p = .354</td>
<td></td>
</tr>
<tr>
<td>CI</td>
<td>-.8868</td>
<td>.2040</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 8)</td>
<td>( 8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = .003</td>
<td>p = .628</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAI (State)</td>
<td></td>
<td></td>
<td>-.2480</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( 8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = .554</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. BDI = Beck Depression Inventory; SA = State Trait Anxiety Inventory- State Anxiety; TA = State Trait Anxiety Inventory - Trait Anxiety; CI = Coopersmith Inventory.
REFERENCES


