

**ART THERAPY WITH THE SEXUALLY ADDICTED CLIENT:
AN ADVANCED WORKSHOP FOR CLINICIANS**

by

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**A Master's Research Project Submitted in Partial Fulfillment
of the Requirements for the Degree**

Master of Arts

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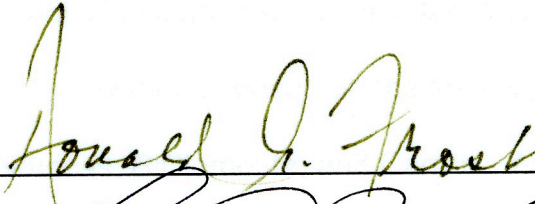
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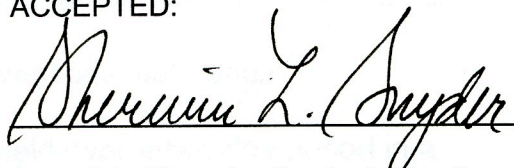
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ABSTRACT

The purpose of this study was to develop an advanced workshop for the clinician presently working in the field of sexual addiction. This experiential workshop combines art therapy interventions with the recovery model of Alcoholics Anonymous.

The data for this workshop was based upon the researcher's training as an art therapist, clinical experience with sexually addicted clients and literature on addictions. The workshop is based on the six stages of addiction as defined by Prochaska, Norcross, DiClemente, and Carnes. Art therapy interventions employed in the workshop correspond to each of the stages of addiction. Workshop participants are asked to experience each of the art therapy modalities with the dual goals of educating the participants in art therapy interventions and experiencing the interventions first-hand.

The workshop is designed to be held over a two-day period in a comfortable setting with art materials provided by the workshop facilitators. The workshop facilitator needs to be trained in both art therapy and in the treatment of sex addiction.

TABLE OF CONTENTS

CHAPTER

1.	THE PROBLEM	1
	Introduction	1
	Development	1
	Need for the Study	4
	Purpose of the Study	5
	Research Question.....	5
2.	LITERATURE REVIEW	6
	Addiction.....	6
	Sex Addiction	8
	Twelve-Step Model of Alcoholics Anonymous	12
	Art Therapy and Addiction	14
	Summary	17
3.	METHODOLOGY	18
	Introduction	18
	Research Design.....	18
	Source of the Data	19
	Workshop Objectives	19
	Rationale for Using the Art Therapy Model with Sex Addicts	19
	Conclusion.....	20
4.	WORKSHOP CONTENT	21
	Introduction	21
	Day One	22
	Opening Ceremony - Day One	22
	Stage One	23
	Stage Two	24
	Stage Three.....	29
	Stage Four	31
	Closing Ceremony - Day One	33
	Day Two	33
	Opening Ceremony - Day Two	33
	Stage Four.....	34
	Stage Five	35
	Stage Six	37

5.	Chapter 5	39
	Summary	39
	Conclusions	40
	Recommendations	42
	REFERENCE LIST	42

CHAPTER 1

THE PROBLEM

Introduction

The advanced workshop described in this study introduces the use of art therapy as an adjunctive modality in the treatment of the sexually addicted client. The workshop is designed for the clinician who is currently working in the field of sex addiction. It is presumed that the clinician will have a working knowledge in the field of addiction and will be familiar with the twelve-step model of Alcoholics Anonymous.

Development of the Problem

Since the inception of Alcoholics Anonymous in 1935, the twelve-step model for recovery has been used by various anonymous groups. These anonymous groups include, but are not limited to, alcohol, sex, working, gambling, debt, spending, and food.

It wasn't until the 1970s that researchers and clinicians, particularly those working in substance abuse, noticed that patients often exhibited excessive behaviors around food, gambling, and sex that were similar to drug and alcohol abuse (Solomon, 1974).

It was during this era that R. Solomon (1974) introduced the opponent-process theory of addiction which proposed that any behavioral excess could lead to dependence on the behavior to feel normal. Also during this time, research on the brain's neurochemistry led to an awareness that addiction exists within the body's own chemistry without external chemicals. In 1977, the National Science Foundation identified sex addiction as a priority research area in the field of addiction (Carnes, 1990).

Since then, professionals from a variety of fields have continued to explore and define the nature of sexual addiction, to formulate treatment approaches, and to place treatment approaches in a family system context. (Carnes, 1990, p. 1)

There are clinicians who argue that excessive behavior cannot be called an addiction. They point out that addiction requires physiological dependence on a chemical substance arising from habitual use. This group may identify the behavior as a compulsion or a behavior disorder, but not an addiction (Coleman 1986, Levine and Trorden 1988, Nathan 1995).

Coleman (1986), a critic of the sexual addiction model, introduced the term sexual compulsion to sexologists thinking the term to be less negative than the term addiction, even though he used the exact same criteria for compulsion that had been used for sexual addiction. Levine and Trorden (1988), the harshest critics of the sexual addiction model, stated that sex addiction is seen in the context of pathologizing deviance and think 12-step groups are sex negative.

R. Nathan (1995) states that therapists prefer the medical term compulsion to the term addiction. For the purpose of this study, it is not this clinician's intention to debate this issue, but rather to accept the addiction model of excessive sexual behavior, to identify the behavior as sexual addiction and to support this interpretation with the use of art therapy as an adjunctive treatment modality.

Similar to clinicians that disagree on the terminology of addiction, society disagrees on the subject of sex. On the one side sex sells and people buy. Millions of dollars are spent on the Internet, pornography, prostitution and 900 numbers that sell sex talk. On the other side, society is horrified by the increase in sex crimes, the increase in sexually transmitted diseases, kiddie porn and child abuse. This splitting in society is similar to the polarized thinking of the addict. Polarized thinking (all good—all bad) keeps the addict stuck into the cycle of acting out behaviors, feeling shame for the acting out, and keeping the acting out behaviors secret because of the shame of disclosure.

Clinicians know that the greatest healing agent to both secrecy and shame is "talk" therapy, telling the story, getting the secrets out. Because of the shame associated with sexual secrets, disclosing becomes very difficult. However, unless the secrets are exposed, the shame will not be reduced and the behaviors will continue. Art therapy is an alternative method of exposing the secrets and reducing the shame.

Art therapy provides another language, a bridge for the clinician to use in connecting with the client in a safe and non-threatening manner. Art therapy provides safety by allowing the addict to be in charge of his/her own process. Insight is revealed not through the therapist but through the addict's unconscious. The act of creating can be cathartic empowering and healing.

Milkman and Sunderwirth (1984) state "when you can't control when you start or stop the activity, when it begins to damage you and your close relationships, you're addicted" (p. 4).

Dr. Patrick Carnes, who wrote the groundbreaking book Out of the Shadows: Understanding Sexual Addiction (1983), was the first to bring the term sexual addiction to the general public. According to Carnes, sexual addiction is defined as any sexually-related, compulsive behavior which interferes with normal living and causes severe stress on family, friends, loved ones and one's work environment.

It must be noted that no single sexual behavior constitutes sexual addiction. It is only when a behavior has taken control of the individual's life that it is then called an addiction (Carnes, 1983).

Need for the Study

This workshop is designed as an innovative, comprehensive and stimulating addition to the traditional addiction model of recovery. A popular saying in twelve-step lore is, "The definition of insanity is doing the same thing

over and over and expecting different results” (anonymous). Clinicians can also become rigid and stagnant in the treatment of the addict. The use of art therapy as an adjunct to cognitive and behavioral approaches is one way for the clinician to offer a wider range of treatment options. The use of a variety of effective treatment modalities may help the clinician to maintain a vibrant and fresh approach to their practice, helping to prevent burnout.

Purpose of the Study

The purpose of this study was to develop an advanced workshop to train clinicians in the use of art therapy for the treatment of the sexually addicted.

Research Question

What is the content of a workshop to train clinicians in the use of art therapy for the treatment of the sexually addicted?

CHAPTER 2

LITERATURE REVIEW

Addiction

In the first moments after their birth, children are more closely related to their creator (God) than to their new parents. Carl Jung (1968) referred to the newborn as the Divine Child. Marilyn Murray (1991) referred to the newborn as the Original Feeling Child. Newborns have not yet adapted into the system they have entered.

The Divine Child (Jung, 1968) will cry when wet or hungry and will coo when satisfied and nurtured. As time goes by, and depending upon the circumstances of the system in which the Divine Child (Jung, 1968) has entered, the child will make adaptations to survive. Some children will have to make relatively few changes. Others will adapt and become like their controlling influences. The adaptations the child makes are designed to survive the system,

The gifted child who adapts, to parental demands always tries to understand this absurdity and will accept it as a matter of course, but he has to pay for this pseudo-understanding with his feelings and his sensitivity to his own needs, ie[sic], with his authentic self.(Miller, 1981, p. 251)

This adapted self will have difficulty remembering the Divine Child (Jung, 1968).

One adaptive method seeded in childhood is addiction. The word addiction is derived from the root word addicere, which means to give oneself up,

or to devote or surrender oneself to something habitually or obsessively. When the Divine Child (Jung, 1968) is silenced and forgotten, the addiction becomes the child's new language.

According to Nakken, when a person becomes addicted, the personality splits into two distinct parts, each denying the existence of the other (cited in Kasl, 1992, p. 26). "It is important not to see the addiction as bad, but rather to understand that the underlying intention of addictive behavior is to find love and to feel good" (cited in Kasl, 1992, p. 10).

While the seeds of addiction are planted in childhood, clinicians usually do not see the fruit of the harvest until it is overripe and rotting. "Addiction has become a popular term because it gives us a concrete way to describe an experience most of us recognize, an obsessive dependency on people, substances, money, material goods, or situations" (Kasl, 1992, p. 15). The five criteria used to determine addiction are 1) powerlessness to stop at will, 2) harmful consequences, 3) unmanageability in other areas of life, 4) escalation of use, and 5) withdrawal upon quitting (Kasl, 1992, p. 20). It is clinicians' responsibility to carefully tend, eliminate and nurture until the Divine Child (Jung, 1968) is once again recognized, cared for, and allowed to flourish with a new healthy language to replace the language of addiction.

"All addiction is attachment and the recovery process from all addiction requires breaking the attachment" (Chickeineo, 1993, p. 7). "The addict like

most everyone else usually does not make significant life changes until a crisis provokes sufficient pain in his or her life so that he or she must make changes" (Adelman, Castricone, 1986, p. 55). Loss of employment, family and health (i.e., HIV) are three pain-producing events that bring the addict in for treatment.

Sex Addiction

If the root word of addiction, *addicere*, means to give oneself habitually or obsessively, then sex addiction means to give oneself up habitually or obsessively to sex (Random House Webster's College Dictionary, 1997, p. 15).

. Carnes (1983) equates sex addiction to alcoholism. The common definition of alcoholism or drug dependency is that a person has a pathological relationship with a mood-altering chemical. Carnes states that sexual addiction is parallel to alcoholism only that a mood-altering relationship or event be substituted for mood-altering chemical.

"To begin understanding sex addiction, it helps to think of sex as a drug, the sex addict's drug of choice" (Earle and Crow, 1989, p. 15). Aviel Goodman (1992) however, felt that these definitions were not sufficient and introduced a definition that was, "sufficiently specific to be scientifically useful" (p. 305).

According to Goodman (1992), sexual addiction is defined as a disorder in which sexual behavior that can function both to produce pleasure and to provide escape from internal discomfort is employed in a pattern characterized by (1)

recurrent failure to control the sexual behavior, and (2) continuation of the sexual behavior despite significant harmful consequences.

Diagnostic criteria for sexual addiction are:

- 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; and/or
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 (Goodman, 1992, p. 230).

Goodman (1992) believes that by using this diagnostic criteria for sexual addiction, therapists may be prevented from making a stigmatizing diagnosis that may have more to do with the client not conforming with the moral values of the prevailing culture. "It is not the type of behavior, its objects, its frequency, or its social acceptability that determines whether a pattern of sexual behavior qualifies as sexual addiction; it is how this behavior pattern relates to and affects the individual's life, as specified by the diagnostic criteria" (p. 307).

In other words, "when sex is separated from love and care, it can become addictive" (Kasl, 1992, p. 10). The question becomes, if we can apply the definition of disease as a lack of ease, or an impairment of normal functioning, then yes, it can be called a disease" (Kasl, 1992, p. 20). "Sex addiction, like all other addictions, is a disease of the body, mind, and spirit - affecting how addicts behave, feel and think" (Earle and Crow, 1989, p. 20).

Earle and Earle (1995) define the unresolved childhood issues that plague sex addicts as low self-esteem, abandonment fears, blurred boundaries, mood disorders, dehumanizing sexual attitudes, undeveloped social skills, secretiveness, superficiality, distrust, escape strategies, isolation and profound loneliness (pp. 14-17).

Twelve-Step Model of Alcoholics Anonymous

While Carnes, Earle, Kasl, and Goodman, all leaders in the field of sex addiction, may not agree on the exact definition of sex addiction, they do agree that the twelve-step model of recovery is important in the successful treatment of the sexually addicted client. In 1993, Carnes published, A Gentle Path Through the Twelve Steps, a workbook to be used in conjunction with twelve-step meeting attendance. The Earles (1995) state in their book, Sex Addiction Case Management, that the twelve-step groups modeled after Alcoholics Anonymous have an excellent track record in helping addicts through their recovery (p. 76). Aviel Goodman (1992) states, "Twelve-step groups offer, (but do not impose) a non-judgmental, non-dogmatic, spiritual foundation" (p. 242).

On the subject of brain chemistry associated with addiction (i.e., neurotransmitters, dopamine, and serotonin), Nash (1997) reports that, "One of the most hopeful messages coming out of current research is that the biochemical abnormalities associated with addiction can be reversed through learning. For that reason, many psychological interventions ranging from psychotherapy to twelve-step programs can and do help" (p. 76).

While leaders in the sexual addiction field are in agreement about the benefits of the twelve-step model of recovery, none would use it solely in the treatment of their clients.

The Earles (1993), in Sex Addiction Case Studies Management, report a multi-modal approach in treating sex addiction using Gestalt, Edu Therapy, Cognitive, Group, Inner Child, Art and Sandplay Therapy. In her 1992 book, Many Roads One Journey Moving Beyond Twelve Steps, Kasl finds the mandala as a beneficial way to look at recovery from addiction. Kasl (1992) conceptualizes healing and recovery from addiction on a continuum.

The problem with linear models it[sic] they don't leave room for individual differences. A person doesn't pass from one phase to another on a given day and often there are areas of a person's life in different phases at the same time. These phases can be seen as general categories that overlap or perhaps as a spiral where we come again and again to a similar situation but view it from a different perspective or a heightened awareness. People may want and need to belong to different phase groups simultaneously. Another way to view this process is with the mandala where we become whole by incorporating different aspects of growth in out[sic] own special way. (p. 357)

Wadeson (1980), one of the founding art therapists, makes a similar case for the use of art as therapy when she observed, "Verbalization is linear communication. First we say one thing, then another. Art expression need not obey the rules of language, grammar, syntax, or logic. It is spatial in nature. There is no time element. In art, relationships occur in space. Sometimes this form of expression more nearly duplicates experience" (p. 11).

Art Therapy and Addiction

With art therapy, the image of a dream, fantasy or experience is depicted in image form rather than having to translate it into words.

Because of the permanence of the object produced, the picture or sculpture is not subject to the distortions of the memory.

Art is a less customary communication vehicle and less amenable to control-allowing things totally contrary to what the creator has in mind.

Art is executed through the body and it may be a way of activating all one's functions. The simultaneous use of these functions assists in the integration of the personality.

In a 1994 report by the Safer Society Program and Press, thirty-three percent of the providers use art therapy in the treatment of the sex abuser. In Liebmann's (1994) book, Art Therapy With Offenders, Maralynn Hagood states in her work with adolescent sex offenders, "The use of art therapy supplemented counseling in a comfortable way and the boys in the group readily and easily accepted its use" (p. 216). Hagood also states that there is an addictive component to sexual offending (p. 200).

Dr. Barbara Bagan - Prochelo states that the defensive system of the sex addict is so well developed and strong that art therapy, a right-brained activity, can break through the left brain defenses (cited in Earle and Earle, 1994, p. 199).

Because the addict's defenses are cut through more quickly with the use of art therapy, family of origin and childhood trauma are more accessible for the clinician using the art therapy modality. "Art therapy can help to retrieve childhood memories and gain insight into the present situation" (Liebmann, 1994 p. 201). Because so many sex addicts and co-addicts are emotionally or psychologically stunted, the use of art therapy with this population is similar in using art therapy with children (cited in Earle and Earle, 1994, p. 200). Art therapy offers another language and another way to communicate. It provides safety and helps to establish rapport.. Bagan - Prochelo observes, "going to a therapist can be scary for anyone, adult or child. Art therapy can break down this barrier of distrust" (cited in Earle and Earle, 1995, p. 200).

. Carnes (1990) states that ninety-seven percent of sex addicts surveyed experienced emotional abuse, eighty-one percent experienced sexual abuse, and seventy-two percent experienced physical abuse as children. It is clear from these statistics that sex addicts have childhood abuse and trauma issues that must be addressed in therapy. Some clients can easily access the abuse and trauma; others cannot. "Verbal therapies alone may not adequately access, release, and integrate the denied, repressed or blocked affect" (Earle and Earle, 1995, p. 204). Art therapy can provide an important modality with which to do deep work with clients.

A question frequently asked by clinicians and clients is, what exactly is art therapy? Because art therapy is experiential, this question is more easily answered by doing rather than hearing or seeing. While some therapists use art work to help with diagnosis and others use art therapy to help improve a client's coordination and motor skills, neither of these uses are the main purpose of using art therapy with the sex addict.

Art therapy with the sex addict is person centered for insight and awareness. "Process oriented therapy concentrates on exploring how individuals create rather than what they create" (Earle and Earle, 1995, p. 207). The end product becomes secondary to how the client selects and handles the material. "The art medium often stimulates the production of images, tapping into primal process material and enhancing the creative process, both narrowly in an artistic sense, and broadly in the creation of solutions in living" (Wadeson, 1980, p. 9).

Margaret Frings Keyes (1974) states, "Men have always used the arts of music, poetry, dance, drama, painting, writing and sculpture to symbolize, explore and say what could not be said in words" (p. 1). Often art accesses feelings better than words. Florence Cane states, "Primitive man used his creative ability naturally in making his clothes, utensils and habitation. We should learn from him and use art freely in our lives to bring back the balancing and health giving qualities of creating" (p. 303).

Balance in mental and physical health are two components often missing from the sex addict's life. A third component important in the recovery process for the sex addict is a connection to a sense of spirituality which can also be accessed through the creative process. "Through creative activity, we can enter into a timeless space where there is rest. There is a Greek word, *Kairos*, which means timelessness and it is used in the Bible to describe the kind of time zone God lives in (cited in Chickeino, 1993, p. 15).

Shaun McNiff (1989) states, "The arts are soul's manifestations and expressive language" (p. 5). He goes on to say, "Each art work is an awakening or liberation of the soul" (p. 7). Madeline L'Engle, a children's author wrote, "the true artist is really a servant of the work which transcends conscious knowing and comes from God." (Chickeineo, 1993).

Summary

Three main topics reviewed in this chapter were addiction, sex addiction and art therapy. Addiction literature included cognitive and behavioral approaches to the treatment of addiction. Sexual addiction literature reviewed included the majority of writings by noted clinicians in the field. Art therapy literature reviewed included works by the original founders of the art therapy school and current information available applying art therapy to sexual addiction.

CHAPTER 3

METHODOLOGY

Introduction

The purpose of this study was to develop a workshop to train clinicians in the use of art therapy in the treatment of the sexually addicted. The research question addressed in this study was: what is the content of a workshop to train clinicians in the use of art therapy for the sexually addicted?

Research Design

This study utilized descriptive research design. According to Merriam and Simpson (1995),

One of the most commonly used methodologies in the study of adult education and training is descriptive research. In descriptive research, the researcher does not manipulate variables or control the environment in which the study takes place. Its purpose is to systematically describe the facts and characteristics of a given phenomenon, population, or area of interest. Description may include (1) collections of facts that describe existing phenomena; (2) identification of problems or justification of current conditions and practice; (3) project or product evaluation; or (4) comparison of experience between groups with similar problems to assist in future planning and decision making. (p. 61)

Source of the Data

The data for this workshop was based on the researcher's training as an art therapist working with a sexually addicted client base and literature on addiction.

Workshop Objectives

1. To teach clinicians art therapy interventions to compliment their previous training in the addictions field.
2. To provide clinicians the tools to integrate and implement these art therapy interventions into their practice.
3. To provide a professional group experience in which clinicians gain insight into how art therapy can be used as a treatment modality for clients with sexual addictions.

Rationale for Training Clinicians in the Utilization of Art Therapy with the Sexually Addicted

Art therapy provides 1) an effectual avenue to the unconscious, and 2) an alternative to verbal communication which may be difficult for the addict, 3) safety and support for the client in exploring his/her own process without

influence from the therapist, and 4) freedom from the constraints imposed by a one-dimensional, cognitive therapeutic approach.

It has been this clinician's experience that art therapy can help to assist the sexually addicted client in dealing with the shame and denial that keeps him or her stuck in the addictive cycle. Insights into past traumas, unconscious behaviors and the client's attitudes, beliefs and values are possible through art therapy. It is sometimes only through art therapy that the sex addict is able to initially respond and communicate with the clinician. Art therapy can often be the catalyst to opening up the sexually addicted client to more traditional modalities, and facilitating the recovery process.

Art therapy interventions selected for the workshop include modalities

Conclusion

Art therapy interventions selected for the workshop include modalities learned during this clinician's academic study and training as an intern therapist under the supervision of specialists in the field of sexual addiction treatment.

CHAPTER 4

WORKSHOP CONTENT

Introduction

This advanced art therapy workshop is for the clinician familiar with both the field of sex addiction and with the twelve-step model of recovery.

The workshop will be held over a two-day period. Each day, two six-hour, working sessions will be scheduled with one hour for lunch. After the first day, each participant will be asked to complete a voluntary homework assignment and to be willing to discuss the process during the morning of the second day.

The maximum number of participants will be limited to ten. The participants will do individual and group art therapy processes in the workshop. It is believed that ten participants is an appropriate number given the space requirements for art preparation and group participation. The workshop meeting room needs to be large enough to allow for the group and individual activities. One wall of the workshop room needs to be large enough to accommodate six-foot long sections of butcher-block paper that will be taped up on an individual basis during some of the group sessions. Working tables, large enough for the

individual art therapy working sessions, will be included in the workshop meeting room layout.

Participants will be asked to wear loose fitting, comfortable clothing in which to work. They will be asked to sign a confidentiality statement because of the therapeutic nature of the workshop and the sensitivity of the subject matter.

The workshop facilitator will be a trained art therapist with a background in working with sex addiction. It is important that the facilitator have personally experienced the modalities that will be covered in the workshop. The facilitator must be aware that all art therapy materials need to be included in the workshop because of the need for consistency in each of the art therapy working sessions.

The facilitator will open the workshop by self-introduction and an explanation of the process of the workshop. The workshop is experiential; each element of the process will be revealed to the workshop participants as the prior element is concluded. Overall goals for the workshop will be addressed by the facilitator during the introduction.

Opening Ceremony

The first experiential element will be a Native American style “naming” ceremony. The purpose of this ceremony is for each participant to be able to introduce himself or herself to the group and for the group to develop initial bonding. Group members will be assembled into a circle. A rain-stick will be

used as a focal point for individual sharing. Each group member will hold the rain-stick, turn it over and share with the group their name and something they would like the group to know about them. After the participant concludes his or her sharing, the rain-stick will be passed to the next group member and on around the circle. Generally, the facilitator will be the first to share in the group to set an example of group participation and to assist the participants in overcoming the fear of speaking in front of a group of strangers.

Stage One

At the conclusion of the naming ceremony, the facilitator will introduce the first stage of addiction, which is called the pre-contemplation stage (Prochaska, Norcoss, and DiClemente, 1994) or the developing stage (Carnes, 1993). This is the stage in which the client is unaware of any sexual addiction problem. It is characterized by a high of level of sexual acting out by the client. Unless family or friends prompt a client to seek help, it is highly unlikely that a clinician will see the addict during this stage. If a client does seek help and is not encouraged by the clinician to disclose sexual acting out behaviors, it is probable that the clinician will not be aware of the problem.

Stage Two

Steps One, Two, and Three. The second stage of addiction is the contemplation stage (Prochaska and DiClemente, 1994), or the crisis / decision stage of Carnes' (1993) sex addiction model. The characteristic of this stage is a potential bottoming-out. This stage can last from one day to three months in which the behavior of the sex addict is having a negative impact on his or her life.

At this stage, it is important for the therapist to assist the client in answering three questions: (1) In what ways has the client's life become unmanageable? (2) How has the client's sexual behavior added to the unmanageability of his or her life? and (3) Does the client have a concept of a Higher Power or a sense of spirituality?

At this time, the therapist will introduce the first three steps of the twelve-step model adapted from Alcoholics Anonymous (The Big Book of Alcoholics Anonymous, 1976). Steps one, two and three of the Alcoholics Anonymous model states, "admitted that we were powerless over our compulsive sexual behavior, that our lives had become unmanageable; came to believe that a Power greater than ourselves could restore us to sanity; and made a decision to turn our will and our lives over to the care of God as we understood God" (The Big Book of Alcoholics Anonymous, 1976, p. 59).

Two experiential art therapy interventions will assist the therapist in working with the sex addict during this stage. The first is an exercise incorporating mandalas.

Mandalas represent the magical symbolism of the universe as perceived by ourselves, its intricate construction being contained within the "eternal circle," which in the East represented the Wheel of Life. People's role or quest was to follow the unbroken thread along a pathway that led ultimately to divine union with a universal Creator or Creatrix. (Davis, 1995, p. 7)

A mandala, a Sanskrit word for circle, is a concrete symbol of its creator's absorption into a sacred center (Cornell, 1994, p. 3). The Navajo calls this center a spiritual place of emergence for sacred imagery (Cornell, 1994, p. 3).. Cornell (1994) states six reasons for the creation of mandalas. The mandala (1) has curative powers, (2) has a calming effect and helps to focus and strengthen for healing, (3) can bring a sense of joy, (4) can make the invisible, visible, (5) can reveal unity between human existence and the cosmos, and (6) can give form and expression to an intuitive insight into spiritual truth (p. 2).

Creating the mandala will be the first experiential art therapy intervention undertaken by the workshop participants. Supplies required will be paper, a compass or plate for creating the circle, colored pencils, craypas, or water-based paint. Forty-five minutes will be allotted for the mandala work. The facilitator will demonstrate with slides completed mandalas from different cultures before

asking the participants to begin creating their own mandalas. At the conclusion of the individual creative period, the facilitator will ask the participants to share the feelings they experienced while creating their mandalas. The facilitator will remind the participants that the final art product is not as important as the process that one goes through. Some of the questions the facilitator may ask are: (1) Did it feel like the mandala was a meditative exercise? (2) Did you feel an increased ability to focus and develop a sense of becoming centered? (3) Did any images or symbols come to mind as you were creating your mandala? Participants will then be invited to share their mandalas with the group by individually taping them to a wall area in the meeting room and sharing their feelings, insights and awareness about the process.

At this time, the facilitator may want to share the process of Carl Jung's four-year, self-therapy painting mandalas after severing his professional relationship with Dr. Sigmund Freud. The facilitator may want to also recommend that the mandala intervention may be useful in each client's ongoing spiritual connection and recovery.

The second art therapy intervention to be used in conjunction with this stage and in recovery is a sexual time line. The objective of the sexual time line is to develop a linear representation of the participant's sexual history using the non-dominant hand. This intervention is similar to a first step from the twelve-step model of Alcoholics Anonymous. The non-dominant hand is used because

by using it, it is easier to tap into the intuitive, emotional, artistic, poetic, childlike, and non-rational part of the brain (Capacchione, 1991, p. 9.). The time line is made up of symbols, pictures, and images rather than words. This is less threatening than writing out a sexual history time line in written language form, and provides a more comprehensive and complete experience for the client. Because of the nature of this assignment, it will be assigned at the end of the first day and will be done as homework during the evening hours.

No group sharing of each participant's sexual time line will be required, unless the participant feels comfortable in doing so. Participants will, however, be encouraged to share their timelines with their own therapist or another safe person. If one or more of the participants feels comfortable in sharing their time lines with the group, the facilitator will need to assist the process and encourage the group in creating a safe confidential environment. Because of the nature of the information, when sharing a sexual timeline, the facilitator needs to be sensitive to the participant, and feedback should be given only if requested by the participant.

Materials needed for this art experience will be six-foot lengths of butcher paper, a variety of drawing materials, such as colored markers or craypas. Information given to the participants will be (1) to allow enough time to complete the exercise—at least two hours, (2) to work individually and privately, (3) to be cognizant of the process rather than the final product. This may be the first time

participants have examined their sexual histories, they will be encouraged not to judge themselves and to be gentle with themselves during the process.

Participants will be encouraged to take frequent breaks and to do deep breathing and other relaxation techniques at times during the development of their sexual time lines.

The facilitator will demonstrate specific techniques to develop the sexual time-line. The process begins by starting at the far left side of the paper and indicating one's birth using pictures, symbols or images. Participants will then be asked to continue drawing pictures, symbols and images of their sexual history that should include things that involved the participant either directly or indirectly. Some of the questions the participants may wish to ask of themselves are: (1) Was I a wanted child? (2) What was the sexual atmosphere like in my home? (3) Were my parents affectionate to each other? (4) What were the boundaries like in my home growing up? (5) Was there nudity in my home? (6) Was I exposed to pornography at a young age? (7) Was I sexually shamed? (8) Was I objectified? (9) When did I first masturbate? (10) When did I first have intercourse? (11) How many partners? (12) Have my sexual behaviors included fetishes? (13) Have I ever been molested or have I ever molested, voyoured, or been an exhibitionist?

The sexual time line intervention is a sensitive assignment. It is important for clinicians to experience this process for themselves in order to be sensitive to

the difficulties that may be encountered when an individual client is working his or her sexual timeline.

Stage Three

Prochaska, Norcoss, and DiClemente's (1994) third stage of the addiction model is the preparation stage. Carnes (1993), in his sexual addiction model, calls it the shock stage. During this stage, the sex addict's pain and the magnitude and severity of addiction surface. This stage is characterized by the addict starting to experience loss and pain as the addict becomes involved in this process. Memories will surface at this time and the clinician will introduce the fourth and fifth steps of the twelve-step model adapted from Alcoholics Anonymous (The Big Book of Alcoholics Anonymous, 1976, p.59).

Steps four and five from the twelve-step model of Alcoholics Anonymous ask the client to, "make a searching and fearless moral inventory of ourselves; and to admit to God, to ourselves, and to another human being the exact nature of our wrongs" (The Big Book of Alcoholics Anonymous, 1976, p.59).

The facilitator will introduce the self-box art therapy intervention that will be used in facilitating the client's fourth step inventory. Some of the questions that will be addressed by the participants are: Who am I? What are my secrets? What do I show the world? What are my defenses? Each participant will be given a box that will become a representation of themselves. Materials needed for this intervention will be cake boxes from a bakery, paints, glue, scissors, a

variety of magazines, glitter, ribbons, colored paper, string, tissue, buttons, cotton balls and any materials that the participants may wish to use in making their boxes. They will be asked to decorate both the inside and outside of their individual boxes. The inside represents the parts of the self that the participant keeps private and may have more difficulty sharing. The outside of the box is the part of the self that is visible and freely portrayed to the world. Approximately one hour will be dedicated for the participants to decorate their individual boxes. Participants will be asked to refrain from talking during this time.

At the completion of the self-box creative process, the group will be assembled in a circle. Participants will be invited to share both the inside and outside of their completed boxes. As always, this is a voluntary process, but it is hoped that all participants will feel comfortable enough to share at least some part of their self-boxes with other group members.

After the individual sharing is completed, the facilitator will encourage each participant to place their individual boxes within the circle formed by the group. This part of the intervention is called a moving mosaic. Participants will place their boxes within the circle wherever they feels most comfortable. While the group participants are showing their boxes, meditative music will be played in the background. Participants will be allowed to move their boxes any number of times until the entire group is comfortable with each participant's box location and the exercise feels complete. The group will then process the exercise. They

will be encouraged to discuss how they felt while their self-boxes were being moved to their final location in the circle, what the experience was like for them and to tell what motivated the moves they made.

The facilitator may point out to the participants how the self-box intervention may be used with their clients to highlight the incongruent inner and outer self, and help to facilitate the completion of a fourth and fifth step of the twelve-step model of recovery adapted from Alcoholics Anonymous. The moving mosaic will help participants get a non-verbal sense of how they work and fit in a particular group setting.

Stage Four

The fourth stage of addiction is the action stage (Prochaska, Norcross, and DiClemente, 1994). Carnes (1993), in his sexual addiction model, calls this stage the grief stage. This is the most visible stage of recovery and may last four to eight months. During this stage, the sex addict grieves the loss of the addiction and begins to exhibit positive behavioral changes.

The sixth and seventh steps from the twelve-step model adapted from Alcoholics Anonymous will be introduced by the clinician during this stage. Steps six and seven ask the client to, “be entirely ready to have God remove all these defects of character and to humbly ask God to remove our shortcomings” (The Big Book of Alcoholics Anonymous, 1976, p. 59).

The art therapy intervention introduced at this time, to facilitate this stage of addiction and the steps of recovery, is called a body contour drawing.

Workshop participants are divided into pairs. One participant lies on a full body length of butcher paper while the participant's partner draws a contour outline of the prone participant's body. When completed, places are exchanged and the other participant's body contour is drawn on another sheet of butcher paper.

After completion of the outline contours, each participant is given a list of affect words such as shame, anger, pain, sadness, lonely, afraid and hurt. These affect words are typically ones that most people feel uncomfortable expressing and they will often carry these emotions within their bodies rather than expressing them appropriately.

Participants are asked to complete the body contour drawing by adding facial features, hair and other distinguishable physical body characteristics. Next, they are asked where they hold these feelings in their bodies. Each participant will share with their partner the feelings they identified and where those feelings are possibly held within their own bodies.

After completing the first part of the body contour intervention, the participants will be given another list of feeling words such as happy, hopeful, serenity, excitement, enthusiasm, and spontaneity. They will be asked to repeat the identification exercise using these feelings and if and where they keep these feelings in their bodies. Participants will then share with their partners the

feelings and associated body locations identified. Each participant will be asked to tape their completed body contour drawing on the wall, and will be invited to share with the larger group any feelings and awareness encountered while participating in the intervention.

Often sex addicts' body contour drawings will be dominated by either the overwhelmingly negative or, in some cases, complete lack of negative and overwhelmingly positive feelings. These results are consistent with the polarized thinking of the addict. This intervention will assist the sex addict client in owning and integrating the positive and negative feelings into his or her conscious identity.

As the session draws to a close, the participants will be given the sexual timeline homework assignment. Following this, the closing ceremony for day one will be conducted.

Closing Ceremony - Day One

The closing ceremony will be the naming ceremony as conducted at the beginning of the day. This will conclude the first day of the workshop.

Opening Ceremony - Day Two

The opening will be the naming ceremony using the rain-stick. This time, however, participants will be asked to share their names and something about themselves that they are uncomfortable sharing with the group. While this may be uncomfortable for some of the participants, it will give them a sensitivity of

what their clients may feel when they are sharing their deepest secrets with them. It has been observed that this intervention can more deeply bond the group together and may result in a much more meaningful workshop for the participants.

The final intervention for this fourth stage of recovery will be a guided imagery, drawing and good-bye letter to the addict. In the guided imagery, the facilitator will do a relaxation exercise and guide the participants back in time to when their life may have been out of control. After finishing the guided imagery, participants are given an 11-inch by 17-inch blank piece of paper and asked to create their guided imagery visualization with craypas or colored markers. Participants are then asked to compose a eulogy-letter to the addict or shadow (Jung, 1968) part of themselves. The objective of this intervention is to not forget the out-of-control aspects of oneself, what Carl Jung called the Shadow. Often the addict wants to deny the Shadow aspect of him/herself. The Shadow holds the greatest potential for healing. When addicts break through denial and realize the importance of this aspect of self and how it has served them like a friend, it allows addicts to move through the other appropriate cycles of grief such as fear, anger, and acceptance. Denial of the Shadow aspect of self keeps the addict stuck in polarized thinking of all good or all bad and the concept of perfectionism which is unattainable.

Stage Five

The repair stage of sexual addiction, as noted by Carnes (1993), is eighteen to thirty-six months into recovery. By this time, because addicts should not be so caught in the addictive cycle, they are ready to do some deep psychological work. This stage is a compliment to the eighth and ninth step adapted from Alcoholics Anonymous (The Big Book of Alcoholics Anonymous, 1976, p.59).

Step eight asks the client to make a list of all persons they have harmed and to become willing to make amends to them all. Step nine challenges the client to make direct amends to such people wherever possible, except when to do so would injure them or others.

The facilitator, familiar with the Karpman Triangle (1968, pp. 39 & 40), the model that depicts the roles of perpetrator, rescuer and victim, and the different roles of Adult Children of Alcoholics, hero, scapegoat, lost child, mascot as identified by Wegschider-Cruse (1989, p.86), will adapt and integrate these two theories to be used with the family of origin work through the use of art therapy.

The participants will be asked to draw or paint their family of origin using symbols or animals representing different family members. Participants will be encouraged to show family members interacting. It is important that the client understands that the roles symbolized in their drawing or painting create a Drama or Karpman Triangle (1968, pp. 39 & 40). Used in conjunction with steps

eight and nine of the twelve steps of Alcoholics Anonymous, this exercise will help clients discover what roles they adopted in childhood in order to survive. Clients will also discover how these roles and the Drama have been used to victimize themselves and others.

The participants will be asked to write a scene from the Drama.

In writing the scene, using their picture, they will be asked to write each family member's lines. This exercise will assist clients in understanding how they continue to keep playing familiar roles in the family drama and will help to identify how others are effected by the drama.

After the participants have finished the scene from their drama, they are to give the drama a title. The clinicians are then invited to share their own roles, drama, scene, and process in the group setting.

Step nine of the Alcoholic Anonymous model asks the client to make "direct amends to such people wherever possible except when to do so would injure them or others" (A.A., 1976, p.59). Webster defines amend as to correct, improve or to change (Webster, 1997). The objective of the next art therapy intervention is for the client to be able to re-frame, to change, or to rewrite the script. According to Carnes (1990), working the steps up to and including step nine is one of the most effective methods of relapse prevention.

At this point, the workshop participants will be led through a guided imagery to help create a vision for the future. As a containment exercise, the

workshop facilitator will ask the participants to visualize a safe place, symbols, images, artifacts and people that will help to create their vision for change. After the visualization, each participant will be given a piece of clay and asked to create a symbol or image from the visualization exercise.

Stage Six

Prochaska, Norcross, and DiClemente (1994) call the final stage of addiction “maintenance.” Carnes (1993) calls this stage the “growth stage,” which is the ongoing process of recovery. Carnes concludes it often requires two to three years to get to the growth stage.

The last three steps of the Twelve-Step model adopted from Alcoholics Anonymous ask the client to, “continue to take personal inventory and when we were wrong, promptly admitted it; sought through prayer and meditation to improve our conscious contact with God, as we understood God, praying only for knowledge of God’s will for us and the power to carry that out; and, having had a spiritual awakening as a result of these steps, we tried to carry this message to other sex addicts and to practice these principles in all of our activities (The Big Book of Alcoholics Anonymous, 1976, p.59).

The final art therapy intervention in the workshop will be the creation of a symbol of empowerment for each of the participants. It is suggested that this symbol be something that each of the participants will be able to take with them at the conclusion of the workshop. As the participants return to their daily lives,

the symbol that they create will enable each of them to reflect on the workshop. In this way, each of the participants will be able to hopefully connect with the important work each of them completed during the workshop. Some suggestions are: a Native American medicine bag, an empowerment stick (decorated and adorned by the participants), a dream-catcher ,or even a significant rock discovered and decorated, or any other personal product created by the participant. It is important for the facilitator to have on hand many different supplies and patterns for this intervention.

After completing the empowerment symbol intervention, participants will be asked to share the significance of their individual creations with the group.

The closing will be a naming ceremony similar to each of the opening ceremonies. In addition, the participants will be asked to share their individual visions for the future in their naming exercise.

After the closing ceremony, the participating clinicians will be given some time to ask questions, to debrief from the workshop and to fill out anonymous surveys asking questions regarding the level of effectiveness of the workshop and suggestions for changes that need to be made.

The facilitator will remind the clinicians that even though the process in the workshop is done over a relatively short period of time, the process could take months or years to complete with their individual clients.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to develop an advanced workshop for the clinician presently working in the field of sexual addiction. This experiential workshop combines art therapy interventions with the recovery model of Alcoholics Anonymous.

The data for this workshop was based upon the researcher's training as an art therapist, clinical experience with sexually addicted clients and literature on addictions. The workshop is based on the six stages of addiction as defined by Prochaska, Norcross, DiClemente, and Carnes. Art therapy interventions employed in the workshop correspond to each of the stages of addiction. Workshop participants are asked to experience each of the art therapy modalities with the dual goals of educating the participants in art therapy interventions and experiencing the interventions first-hand.

The workshop is designed to be held over a two-day period in a comfortable setting with art materials provided by the workshop facilitators. The workshop facilitator needs to be trained in both art therapy and in the treatment of sex addiction.

Conclusions

The nature of sex addiction, that includes the victimization of others, precludes many clinicians offering help to those suffering from this addiction because of the intensity of the subject matter and the clinicians personal prejudices and history. Often clinicians in this field are vulnerable to burnout. This experiential art therapy workshop offers the clinician additional valuable tools in addition to cognitive and behavioral therapy. Through experiential art therapy, the clinician is able to provide another way of communicating that may prove to be more effective than verbal therapies.

The treatment of sexual addiction cannot be taken lightly, with the cost to the society related to health issues such as HIV, the break up of the family from infidelity, and the wounding of children who are victims of sexual abuse, incest and pornography. Art therapy can be used as a viable, adjunctive modality to help in the intervention, treatment and on-going recovery process for the sex addict. Art therapy can be used to help recovering addicts create a new, wider personal and collective view and vision for the future.

It is this researcher's hope that this workshop will be useful in increasing the effectiveness of the clinician who may not have an awareness of the wide range of treatment options with art therapy for those clients with sexual addiction.

The workshop presented in this study is an advanced training workshop in the use of art therapy for the treatment of the sexually addicted client. The workshop is designed to be experiential with the goals of imparting knowledge of art therapy to the participating clinicians and giving the clinicians an opportunity to experience the art therapy modalities for themselves.

The two-day workshop has been segmented corresponding to the six stages of addiction as defined by Prochaska, Norcross, and DiClemente (1994) and Carnes' (1995) stage of recovery from sexual addiction.

Stage one, pre-contemplation, is characterized by the denial of the client to the existence of a problem. It is probable that the clinician will not be involved in the process at this time and, therefore, will not play a role in the recovery process during this stage.

The second stage is defined as the contemplation which is an awareness of the existence of the problem. Mandalas and a sexual timeline are the art therapy modalities that can be applied in this stage.

The third stage is the preparation stage that is characterized by small steps toward changing. Interventions outlined in the workshop are the self-box and a moving mosaic with the self-box.

The fourth stage is the action stage where the major effort on the part of the addict to change behavior takes place. Art therapy interventions applied during this stage is the body-contour drawing and subsequent feelings work

associated with it. Guided imagery and writing a eulogy letter to the addict are additional interventions applied during this stage of addiction.

Stage five from Carnes (1995) is the repair stage. The art therapy modalities used for this stage include a family of origin drawing, learning about the individual's role in his or her family and writing a scene from the family drama. Also, a visualization and creation of a vision for the future for each participant is included in this section of the workshop.

Stage six is the maintenance stage which is the on-going process of recovery and relapse prevention. Interventions applied are the selection of a symbol of empowerment to accompany the participant at the conclusion of the workshop.

Recommendations

The therapist facilitating the workshop must be a trained art therapist with extensive experience in dealing with the sexually addicted client base. The workshop must be held in a comfortable, private setting with ample room to do the various art therapy experiential interventions. The participants need to have comfortable accommodations during the non-workshop hours because of the requirements for homework. The workshop facilitator needs to make sure that all workshop materials are provided.

It is recommended that feedback on the effectiveness of the training workshop be solicited from participants in the form of a questionnaire that will be

given immediately upon conclusion of the training. It will be important to know if the training had an impact on the participants and whether or not the participants learned new information that they may be able to incorporate into their own work with sexually addicted clients. Two follow-up questionnaires will be sent to participants at six-month and one-year intervals after the workshop. At this time, it will be important to know if the training participants have been able to incorporate the training into their work and what effect has the training had on the sexually addicted clients. It is also recommended that research be conducted to evaluate the effectiveness of modalities which utilize art therapy techniques to treat sexual addiction.

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