

Coping Strategies Used by Hypersexual Patients to Defend Against the Painful Effects of Shame

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This article reports the findings of a study investigating coping strategies used by hypersexual patients ($n = 71$), compared with a control group ($n = 73$), in their attempts to defend against shame. Coping strategies were measured using the Compass of Shame Scale (CoSS) and hypersexual behaviour was measured by the Hypersexual Behavior Inventory (HBI). A multivariate analysis of variance of between-group differences was significant, and examination of *post hoc* univariate tests revealed that the sample of hypersexual patients defended against shame with higher levels of withdrawal and higher tendencies to attack self and others when compared with the control group. The effect sizes of these differences were moderate to large. A categorical analysis of the patient group indicated that the greatest percentages of elevated shame scores were clustered on the Withdrawal and Attack Self subscales of the CoSS. Between-group differences on the Avoidance subscale of the CoSS were not significant. The results of this study are discussed as they pertain to clinical practice, and future recommendations for research are offered. Copyright © 2009 John Wiley & Sons, Ltd.

INTRODUCTION

Hypersexual behaviour has been linked to a host of psychological issues, including anxiety, depression (Raviv, 1993; Raymond, Coleman, & Miner, 2003; Reid & Carpenter, in press), attention-deficit disorders (Blankenship & Laaser, 2004; Kafka & Prentky, 1998; Reid, 2007), social phobia, substance abuse (Kafka & Hennen, 2002), obsessive tendencies (Reid & Carpenter, in press; Schwartz & Abramowitz, 2003), sexual dysfunction (Butts, 1992) and post-traumatic stress disor-

ders (Howard, 2007). Personality characteristics such as boredom proneness (Chaney & Blalock, 2006), interpersonal sensitivity, alexithymia, loneliness and low self-esteem have also been observed in association with hypersexual behaviour (Guigliamo, 2006; Reid, Carpenter, Spackman, & Willes, 2008; Yoder, Virden, & Amin, 2005; Wilson, 2000). Some evidence suggests that hypersexuality is also linked to attachment styles that negatively impact healthy romantic relationships (Reid & Woolley, 2006; Zapf, Greiner, & Carroll, 2008). Although the body of literature regarding hypersexual behaviour continues to grow, there is a paucity of research investigating relationships between such behaviour and shame, despite clinical impressions recognizing the role of shame as an associated feature of hypersexual behaviour (Adams & Robinson, 2001; Reed, 2000; Wilson, 2000). This study

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attempts to explore how hypersexual patients, compared with a control group of college men, use coping strategies to defend against the emotionally painful effects of shame.

DEFINING HYPERSEXUAL BEHAVIOUR

The phenomenon of hypersexuality has been discussed from various perspectives, including sexual addiction (Carnes, 1986; Goodman, 1993, 2001; Leedes, 2001; Myers, 1995; Ragan & Martin, 2000; Schwartz & Brasted, 1985), sexual compulsivity (Coleman, 1987, 1991, 1992, 2003; Cooper & Lebo, 2001; Quadland, 1985; Travin, 1995; Weissberg & Levay, 1986), sexual dependency (Wan, Finlayson, & Rowles, 2000), sexual impulsivity (Barth & Kinder, 1987; Gabbard & Bennett, 2005) and hypersexuality (Brandell & Nol, 1992; Finlayson, Sealy, & Martin, 2001; Kafka, 1997, 2001, 2003; Orford, 1978; Reid, 2007; Reid & Carpenter, in press; Rinehart & McCabe, 1997, 1998; Salzman, 1972). Although there is disagreement about what the phenomenon should be labelled, there does appear to be a general consensus that a substantial number of patients are experiencing significant distress and consequences due to a pattern of persistent, intense sexual urges, thoughts and behaviours that are interfering with activities of daily living (Coleman, Raymond, & McBean, 2003). In clinical work, the investigators have often observed that patients use sex as a coping strategy to avoid or escape emotional pain activated by shame or other unpleasant affective experiences (Adams & Robinson, 2001; Harper & Hoopes, 1990; Reed, 2000; Schwartz & Masters, 1994; Wilson, 2000), and although hypersexual patients recognize their behaviour as excessive and impulsive, they report feeling unable to control it despite unpleasant consequences.

Hypersexual behaviour can include either socially deviant or normal manifestations of sexual behaviour involving solo or relational sexual activities. Examples include compulsive masturbation; pornography dependence; protracted promiscuity; multiple extra-dyadic relationships; excessive online sexual pursuits; solicitation of commercial sex workers or use of escort services, strip clubs, or other venues associated with the adult entertainment industry; and telephone sex. When individuals engage in these behaviours to the extent that they experience negative consequences and report a subjective sense of powerlessness over their sexual urges and activities

over a prolonged period of time (e.g., several months), these patterns are hypothesized to constitute hypersexual behaviour (Reid, Carpenter, & Lloyd, 2009).

SHAME AND HYPERSEXUAL BEHAVIOUR

Shame is a complex emotion that is experienced as a painful, self-focused affect (Elison, Lennon, & Pulos, 2006; Parker, 1998) and, like hypersexuality, has been correlated with several manifestations of psychopathology including anxiety, depression, somatization, obsessive-compulsive disorders, aggression, interpersonal sensitivity, substance-related disorders, post-traumatic stress disorders, diminished self-efficacy, violence and low self-esteem (e.g., Baldwin, Baldwin, & Ewald, 2006; Brown, 2004; Gilbert, 2000; Harder, 1995; Lewis, 1971, 1987; Nathanson, 1992, 1994; Tangney & Dearing, 2002). Shame has also been observed among borderline patients who exhibit patterns of sexual impulsivity (Rizvi & Linehan, 2005). Traits such as perfectionism (Ashby, Rice, & Martin, 2006), rumination (Dennison & Stewart, 2006; Joireman, 2004) and alexithymia (Suslow, Donges, Kersting, & Arolt, 2000) have also been noted in the shame literature. Because some of these associations overlap with findings among hypersexual populations, the current inquiry sought to determine how shame might be linked to hypersexuality. This question is complex, in part because the phenomenon of shame itself is represented by multiple perspectives in the literature.

The emotion of shame appears to be a common experience for many people; however, for most, it is a transitory feeling that coincides with guilt and diminishes when guilt subsides. Internalized shame, however, is a more generalized chronic negative evaluation in which the self is perceived as worthless, flawed, broken and defective (Cook, 1994; Kaufman, 1989; Tangney, Miller, Flicker, & Barlow, 1996). In the context of this shame, a person feels powerless to alleviate his/her chronic sense of inadequacy despite many attempts to reduce the painful effects of shame. This perpetual failure can sometimes heighten the shame, leaving a person feeling more demoralized (Adams & Robinson, 2001). This condition is emotionally painful, in part because the individual often feels hopeless to change or recruit alternative perspectives about the self that might have the potential to help him/her feel better (Tangney, 1990).

This debilitating message of shame can evoke fear about what the future might hold (e.g., 'I can't help myself feel better, so I'm doomed to always be this way'). In some cases, shame-based individuals experience internalized anger about their inability to change and it is often manifested by their harsh criticism, contempt and hostility toward the self. Of course, this pattern only heightens their level of shame and depression (Tangney, Wagner, Fletcher, & Gramzow, 1992). They blame themselves for their unpleasant circumstances and believe that their own flaws and inadequacies are responsible for their situation. Multiple failures to alleviate their symptom distress reinforce irrational beliefs about the self, leading to a chronic view of themselves as worthless, inadequate, flawed or defective. This pattern becomes the foundation for creating a vulnerability to hypersexual behaviour as a tranquilizer against the painful effects of shame.

When individuals see themselves as too broken to accept any additional negative messages about the self (e.g., internalized anger, narcissism), potential threats from others or their environment can elicit rage and aggression as the individuals make desperate attempts to defend against shaming experiences. Thus, shame can be a catalyst to attacking the self or others, or, in some cases, both. Empirical evidence supporting this interaction was found in the psychometric validation of the Compass of Shame Scale (CoSS), which built upon Nathanson's shame model that hypothesized four aspects of shame, two of which are Attack Self and Attack Other (Elison, Lennon, & Pulos, 2006; Elison, Pulos, & Lennon, 2006; Nathanson, 1992). These findings suggest, in part, that in addition to studying the shame experience, clinicians should be equally concerned about how patients cope with or defend against it.

SELF-CRITICISM, NEGATIVE AFFECT AND HYPERSEXUALITY

Self-criticism, as a manifestation of shame, has also been connected with vulnerability and proneness to depressive affective states (e.g., Whelton & Greenberg, 2005). One model of depressogenic self-criticism attributes characteristics of shame to introjective individuals where feelings of failure, worthlessness, self-doubt and inferiority are experienced. Depressed individuals with more dependent personality types often experience fear of abandonment by significant others (Blatt

& Homann, 1992; Blatt & Zuroff, 1992) which has also been noted among hypersexual populations (Zapf et al., 2008).

Whelton and Greenberg (2005) found evidence supporting their theory that individuals who are more self-critical also manifest deficits in their ability to defend against the inner harsh critic. One explanation for these results is that individuals who experience more negative affect lack the cognitive flexibility necessary to recruit more positive and affirming self-attributions, a description much like that of shame. In contrast, Fredrickson (2001) found that positive emotion enhances problem solving by facilitating flexible and creative cognitive processes. Fredrickson also discovered evidence supporting the hypothesis that positive emotions increase cognitive resilience by reversing the effects of negative emotion. Thus, it would appear that entertaining or ruminating on negative thoughts interferes with the ability to simultaneously recruit positive thoughts that would evoke more pleasant mood states. These ruminating tendencies, in turn, keep individuals stuck in shame (Ciesla & Roberts, 2007) and hypersexual behaviour (Adams & Robinson, 2001). This pattern also appears to affect interpersonal relationships because shame-proneness has been linked with an impaired ability to generate effective solutions to dyadic problems and with diminished self-efficacy as it relates to confidence in one's ability to successfully implement solutions to relational problems (Covert, Tangney, Maddux, & Heleno, 2003).

In our clinical work, we have noticed that hypersexual patients who tend to exhibit shame inadvertently experience multiple unsuccessful attempts to abandon their behaviour because they lack the cognitive flexibility necessary to think about their situation from a broader range of perspectives. One example of this pattern has been observed among hypersexual individuals who assume that if something bad happens, someone is at fault and therefore someone must be blamed for the unpleasant event—and in many cases, when they are unable to find someone else to blame, they blame themselves. Such polarized thinking perpetuates a pattern of maladaptive coping strategies that keep hypersexual patients stuck, both behaviorally and emotionally, in unpleasant and undesirable circumstances in which they feel helpless and powerless to counter their own self-critical attacks, shame and other negative emotions.

The investigators believe that patients engage in hypersexual behaviour as a maladaptive coping

strategy in order to avoid or disassociate from the painful emotion of shame and contempt toward the self. In this context, sex provides a temporary tranquilizer to inoculate against negative self-criticism and painful shame. In addition to being self-soothing, behaviour involving relational sex or erotic fantasy involving themes of acceptance, adequacy or desirability from another may actually represent attempts to seek validation of one's self-worth as an antidote to emotionally painful shame. As one patient noted, 'My favorite porn sites never reject me.'

ACTION TENDENCIES ASSOCIATED WITH SHAME

Although many measures have been developed to assess shame proneness (e.g., Cook, 2001; Harder & Zalma, 1990; Tangney, Wagner, & Gramzow, 1989), most existing scales do not specifically assess strategies used to cope with shame. The CoSS (Elison, Lennon, & Pulos, 2006; Elison, Pulos, & Lennon, 2006) is a notable exception and was developed based on a model of shame coping styles (Nathanson, 1992) that includes four poles labelled *Withdrawal*, *Attack Self*, *Attack Other* and *Avoidance*. These styles are hypothesized to explain various ways in which individuals react to shaming experiences and to characterize scripts or schemas intended to ignore, reduce or magnify shame, but they neglect to address the source of the shaming event (Elison, Lennon, & Pulos, 2006; Nathanson, 1992). The following descriptions of the four poles of shame were derived from the work of Elison and colleagues in their development of the psychometric properties of the CoSS (Elison, Lennon, & Pulos, 2006; Elison, Pulos, & Lennon, 2006).

Withdrawal

Elevations on the Withdrawal pole indicate awareness of a shaming event as something negative and acceptance of the shaming message as legitimate, which leads to withdrawal from whatever context in which the shame was activated. For example, a hypersexual patient might withdraw from a partner's confrontation or even dissolve a relationship where shaming events are chronically experienced. The motivation associated with this pole is to minimize exposure to shame through the action tendency of withdrawing.

Attack Self

Elevations on the Attack Self pole reflect similar responses to those found in the Withdrawal pole; however, anger related to the shaming event is directed at the self. Manifestations of Attack Self behaviour include contempt, harsh criticism and anger toward the self, which subsequently intensifies the shame. The motivation associated with this pole is to manipulate or control shame by engaging in self-deprecating comments that recruit reassuring affirmations from others. Self-criticism heightens the awareness of mistakes that may have elicited the shaming experience, and it serves as a painful reminder to reorganize future behaviour so shaming events do not reoccur.

Although Withdrawal and Attack Self poles have some similarities, those who attack the self may endure shame in order to preserve interpersonal relationships, whereas individuals who withdraw may sacrifice attachments in order to diminish their personal intolerance and discomfort with shaming experiences.

Attack Other

Elevations on the Attack Other pole reflect attempts to transfer the negative message of shame to others and alleviate one's own emotional pain associated with the shaming event. Anger is manifest to defend the vulnerable self against messages of worthlessness or inadequacy that might have been associated with the shame experience. The motivation associated with this pole is to inflate or bolster the sense of self and externalize the shame by projecting its impact onto others (e.g., demeaning or blaming others). The action tendency of this pole can involve rage and verbal or physical abuse towards others.

Avoidance

Elevations on the Avoidance pole reflect a pattern of behaviour in which the individual does not acknowledge or accept the shame event as legitimate (e.g., denial) and subsequently attempts to distract, dissociate or disconnect the self and others from the painful emotion. Defense mechanisms such as humour or indifference may be employed to detach from the shaming event. The motivation associated with this pole involves minimizing awareness of shame or dismissing the shaming experience as insignificant. Avoidance

is hypothesized to operate outside of conscious awareness.

Use of one of these coping strategies to defend against shame does not necessarily occur independent of other coping strategies or a particular shaming event. It is plausible that an individual might recruit features associated with more than one pole (e.g., Withdrawal and Attack Self). However, a common characteristic of all the poles is that they reflect attempts to cope with shaming experiences and fail to promote successful processing of emotion, which is particularly harmful because unsuccessful processing of emotion may be at the root or source responsible for activating a shaming experience in the first place. In other words, if used chronically, these strategies are maladaptive and do not resolve core issues that might help individuals recruit positive and accurate perceptions of the self and inoculate themselves from unhealthy shame experiences.

RATIONALE AND PURPOSE OF THIS STUDY

Patterns of maladaptive coping strategies used to defend against shame have been noted in clinical populations that possess some similar characteristics to hypersexual patients. Specifically, patients with eating and substance-related disorders have been shown to exhibit maladaptive shame (Bromberg, 2001; Dearing, Stuewig, & Tangney, 2005; Grabhorn, Stenner, Stangier, & Kaufhold, 2006; Hayaki, Friedman, & Brownell, 2002; Murray & Waller, 2002; Swan & Andrews, 2003; Wiechelt & Sales, 2001; Young, 1991). Patients with these disorders show tendencies towards self-soothing, using substances such as drugs or food that activate a pleasure-reward response similar to sex. This pattern, in part, influenced the rationale for the present study, which was designed to determine what relationships might exist between shame and hypersexuality. Specifically, the investigators sought to explore what coping strategies associated with defense against shame are most prominent among a patient sample compared with controls. We anticipated that the patient sample would show significantly higher elevations on the CoSS poles of Withdrawal, Attack Self and Attack Other. We suspected that the groups would not differ on the Avoidance pole because we have observed a tendency among patients to be acutely aware of and accepting of shame experiences, and the Avoidance pole

reflects a diminished awareness and dismissal of shaming messages.

METHOD

Participants

The patient sample used in this study consisted of men ($n = 71$) recruited at the outset of treatment from an outpatient clinic that specialized in the treatment of hypersexuality. Ethnic representation among the sample included Asian ($n = 1$), Hispanic ($n = 1$) and Caucasian ($n = 69$), and participants ranged from 19 to 54 years of age (mean = 30.89, standard deviation [SD] = 7.6). Relationship status included never married ($n = 25$), first marriage ($n = 37$), remarried ($n = 5$), separated ($n = 2$) and divorced ($n = 2$). Sexual preferences included homosexual ($n = 4$), bisexual ($n = 2$) and heterosexual ($n = 65$).

For the patients in this study, a pattern of persistent preoccupation with sexual thoughts, urges and activities interfered with various aspects of their lives, including academic or scholastic goals, employment, marriage relationships or dyads with significant others, parenting, friendships, family associations, personal interests and hobbies. Further, patients reported various consequences for their sexual choices, including legal difficulties (e.g., arrests due to solicitation of sex from a commercial sex worker), financial losses, sexually transmitted diseases, excommunication from their religious faiths and emotional disturbance including feelings of demoralization, loss of self-confidence and diminished motivation.

Self-reported presenting sexual behaviours among the patient sample included compulsive masturbation (63%), pornography dependence (67%), habitual solicitation of commercial sex workers (7%), extramarital affairs (21%) and excessive unprotected sex with multiple anonymous partners (14%). Although some hypersexual patients possess comorbid pathology with paraphilias or have histories of sex-offending behaviour, the sample in this study did not contain any subjects with paraphilias.

The control sample ($n = 73$) was obtained from several undergraduate classes at a local university. A portion of the sample was drawn from evening classes in which non-traditional students participated, providing some data more representative of a community sample (e.g., individuals who worked full-time and were older than the average student). This is reflected in the higher mean age

of the college sample (mean = 25.6, SD = 4.6, range 20–45 years) compared with samples of traditional university students. Ethnic representation among the sample included Asian ($n = 3$), Hispanic ($n = 1$) and Caucasian ($n = 69$). Relationship status included never married ($n = 31$), first marriage ($n = 33$), remarried ($n = 4$), cohabitating ($n = 3$) and divorced ($n = 2$). Sexual preferences represented included homosexual ($n = 2$), bisexual ($n = 1$) and heterosexual ($n = 70$). Subjects reported no history of psychopathology, including sex offenses or paraphilias.

Procedure

The members of the patient sample were selected consecutively based on: (a) a primary complaint reported during intake and assessment being excessive and out-of-control sexual behaviour; and (b) willingness to participate in research, as reflected in consent provided at the outset of the treatment process. We had a 98% rate of participation from those who were invited to be involved in our research. Patients received no incentives to participate, and all subjects in the study signed informed consent. The CoSS, the Hypersexual Behavior Inventory (HBI) and a small battery of several other tests were administered to the patient sample. Patients also received clinical interviews in which they were asked about the nature of their hypersexual behaviour, how their activities had interfered in their lives, consequences experienced in relation to sexual choices and the duration of their sexual behaviour. This data, combined with elevated HBI scores ≥ 53 , were used to classify patients as hypersexual. It should be noted that the majority of the patient sample (96%) had elevated HBI scores. The college sample was given informed consent and invited to participate in this study for extra credit in their courses, and they completed the study measures under a condition of anonymity. We had a 97% response rate from the student sample.

Participants in both samples were eliminated if they had used psychoactive substance in the previous 30 days, exhibited psychotic tendencies or had a history of head injury. These criteria eliminated four subjects.

Measures

Hypersexual Behavior Inventory

The HBI (Reid & Garos, 2007) is a 19-item self-report measure that yields a three-factor solution

that was initially extracted using a maximum likelihood method with oblique rotation on a clinical sample ($n = 324$). The findings were later replicated and confirmed in a second clinical sample ($n = 203$) consisting of patients from treatment clinics across several demographic regions in the USA, including Utah, California, Pennsylvania, Kentucky, Texas and Arizona. The HBI purports to capture the extent to which respondents use sex to cope with emotional discomfort (e.g., anxiety); the degree to which they feel unable to control their sexual thoughts, feelings and behaviour; and the extent to which they experience negative consequences as a result of their sexual activities. Respondents endorse items on a five-point Likert scale ranging from 1 (never) to 5 (very often). The scale has demonstrated high overall reliability ($\alpha = 0.95$) and subscale reliability values of $\alpha = 0.91$ on the Control subscale, $\alpha = 0.91$ on the Coping subscale and $\alpha = 0.89$ on the Consequences subscale. Confirmatory factor analysis (CFA) has provided support on the factor structure, showing an acceptable goodness of fit with a root mean square error of approximation (RMSEA) of 0.057 and a comparative fit index (CFI) of 0.95. The HBI also showed an acceptable goodness of fit using CFA with a mixed college sample ($n = 450$) from Utah, Texas and Kentucky, yielding an RMSEA of .06 and a CFI of 0.95 (Reid & Garos, 2007). Test-retest reliability was derived from a sample of college students ($n = 81$) over a 2-week period. The total HBI score ($r = 0.85$), the Control subscale ($r = 0.87$), the Coping subscale ($r = 0.87$) and the Consequences subscale ($r = 0.88$) all showed high correlations between the first and second administrations, suggesting excellent test-retest reliability over a 2-week time interval. A recommended total scale cut-off score of 53 or higher to classify men as hypersexual was statistically calculated based on the work of Jacobson and Truax (1991). The HBI has shown strong concurrent validity with the Compulsive Sexual Behavior Inventory ($r = 0.92$, $p < 0.01$; Coleman, Miner, Ohlerking, & Raymond, 2001), the Sexual Compulsivity Scale ($r = 0.82$, $p < 0.01$; Kalichman & Rompa, 1995) and the Sexual Addiction Screening Test ($r = 0.73$, $p < 0.01$; Nelson & Oehlert, 2008). The scale also shows excellent sensitivity (0.92) and adequate specificity (0.62) in classifying hypersexual patients (Reid & Garos, 2007).

Compass of Shame Scale

The CoSS (Elison, Lennon, & Pulos, 2006) is a 48-item measure describing situations or experiences that might potentially illicit a shame

reaction, in which respondents endorse choices that load on the four-factor structure and represent four poles: Withdrawal, Attack Self, Attack Other and Avoidance. Rather than addressing shame directly, responses describe related feelings and behaviours. Individuals are instructed to rate each item using a forced-choice frequency rating, ranging from 0 (never) to 4 (almost always). The initial item-reduction was conducted on a college sample ($n = 322$), and a subsequent CFA demonstrated an acceptable fit (CFI = 0.94; RMSEA = 0.055). The CoSS subscales yielded good reliability with subscale values of $\alpha = 0.89$ for the Withdrawal pole, $\alpha = 0.91$ for the Attack Self pole, $\alpha = 0.85$ for the Attack Other pole and $\alpha = 0.75$ for the Avoidance pole (Elison, Lennon, & Pulos, 2006; Elison, Pulos, & Lennon, 2006). The CoSS demonstrated convergent validity with the Internalized Shame Scale (Cook, 2001). In the current study, the CoSS showed good reliability with alpha coefficients on the respective subscales as follows: Withdrawal ($\alpha = 0.90$), Attack Self ($\alpha = 0.92$), Attack Other ($\alpha = 0.92$) and Avoidance ($\alpha = 0.68$).

RESULTS

A multivariate analysis of variance (MANOVA) of the overall differences between the groups for the HBI subscales and the CoSS poles yielded significant results (Wilks' $\lambda = 0.298$; $F[7, 136] = 45.79$;

$p < 0.001$). The results of the *post hoc* univariate tests for each of the dependent variables, means and SDs are noted in Table 1. The groups showed significant differences on all of the study variables except the Avoidance pole of the CoSS ($F[1, 142] = 0.86$; $p = 0.355$). Apart from the differences of hypersexual behavior, the Withdrawal subscale of the CoSS yielded the greatest difference between the groups ($F[1,142] = 29.17$; $p < 0.0001$) followed by scores on the Attack Self pole ($F[1, 142] = 18.35$; $p < 0.0001$). Correlates among the study variables can be found in Table 2. Because the groups are so different on HBI scores, it is possible that the correlations may be mildly inflated; however, as can be seen in Table 1, Withdrawal, Attack Self and Attack Other yielded moderate to large effect sizes as measured by Cohen's d . The correlations in Table 2 listed by group classification suggest that the patient group experience the strongest relationship between shame and hypersexual behaviour for all of the poles except Avoidance and the strongest relationships exist on the domain of sexual behaviour used to cope with challenges, stresses and emotional pain.

Because the average age of the controls (mean = 25.6) and the patient (mean = 30.9) group was significantly different, we divided the data into two even groups by age classification (above and below age 26) and explored differences based on age classification; however, this analysis was non-significant ($p = 0.101$), suggesting that age did not

Table 1. Comparison of Compass of Shame Scale (CoSS) and Hypersexual Behavior Inventory (HBI) mean scores for hypersexual ($n = 71$) and college subjects ($n = 73$)

Variable	Group				<i>F</i>	Cohen's <i>d</i>
	Hypersexual		College control			
	Mean	SD	Mean	SD		
HBI						
Total score	73.10	10.8	36.75	14.1	300.63**	2.89
Control	33.66	4.8	15.34	7.5	297.26**	2.91
Coping	25.75	5.1	15.23	6.1	127.69**	1.87
Consequences	13.69	3.2	6.18	2.6	238.39**	2.58
CoSS						
Withdrawal	61.02	10.3	51.69	10.4	29.17**	0.90
Attack self	56.88	10.1	49.32	11.0	18.35**	0.72
Attack other	53.19	10.9	47.33	9.3	11.92*	0.58
Avoidance	49.89	9.6	48.43	9.6	0.86	0.15

* $p < 0.001$. ** $p < 0.0001$.
SD = standard deviation.

exert an effect on our findings. Similarly, we computed independent *t*-tests on the study variables based on relational status which failed to produce any significant differences between the groups in this sample. The other demographic variables yielded subgroups that were too small to warrant analysis.

Categorical Analysis

In clinical practice, we often think in terms of classification and whether a patient exhibits an elevated score on a given measure. We explored this by first isolating the patient sample and assessing the percentage of patients with elevated CoSS scores (T

Table 2. Pearson correlation coefficients of patient and controls

Patient sample (<i>n</i> = 71)		HBI subscales		
CoSS poles	Control	Coping	Consequences	
Withdrawal	0.27*	0.40**	0.26*	
Attack self	0.25*	0.37**	0.18	
Attack other	0.15	0.34**	0.17	
Avoidance	0.04	0.12	0.05	

Control sample (<i>n</i> = 73)		HBI subscales		
CoSS poles	Control	Coping	Consequences	
Withdrawal	0.39**	0.38**	0.39**	
Attack self	0.40**	0.25*	0.31**	
Attack other	0.38**	0.34**	0.41**	
Avoidance	0.15	0.18	0.21	

*Significance at 0.05 (2-tailed). **Correlations significant at 0.01 (2-tailed).

CoSS = Compass of Shame Scale. HBI = Hypersexual Behavior Inventory.

score ≥ 65) compared with their cohort with non-elevated scores. We then examined the differences of HBI scores between these groups using independent *t*-tests. Because the overall test of significance (e.g., MANOVA) was significant, *post hoc* analysis of separate, univariate comparisons was done to ascertain the likely source(s) of the significance. In such a hierarchical approach to analysis, correction for multiple comparisons at the *post hoc* stage is not strictly necessary; however, for conservative comparison, the critical alpha level using Bonferroni correction is also noted in Table 3. The results in Table 3 list patients with elevated CoSS pole scores compared with patients with non-elevated scores and their respective mean differences on the HBI. As can be seen, the greatest percentage of patients had elevated scores on the Withdrawal (35%) and Attack Self (27%) poles of the CoSS, and these patients also showed significantly higher levels of hypersexuality as measured by the HBI.

Differences between the patient and college groups on the prevalence of elevated CoSS pole scores were also examined, resulting in a significantly greater percentage of patients exhibiting Attack Self tendencies as measured by the CoSS when compared with the college controls. Although the prevalence rates for elevated scores on the Withdrawal and Attack Other poles were not significantly different between the groups, the overall trend shows that a higher percentage of patients had elevated scores when compared with controls (see Table 4).

In examining the data, we noticed that 52% of the hypersexual patients (*n* = 37) did not have clinically elevated scores (T ≥ 65) on any of the CoSS poles. We isolated these patients as a separate group and compared their HBI scores (mean = 68.9) to those of the remainder of their cohort (mean = 77.7;

Table 3. Difference on Hypersexual Behavior Inventory (HBI) scores for patients with and without elevated Compass of Shame Scale (CoSS) scores

CoSS poles	Patients with T ≥ 65 % (<i>n</i>)	Mean scores for HBI		Significance
		T ≥ 65	T < 65	
Withdrawal	35 (25)	79.5	70.2	0.001
Attack self	27 (19)	81.5	70.5	0.001
Attack other	16 (11)	73.1	75.6	0.497
Avoidance	4 (3)	79.0	73.4	0.454

Statistical comparison of elevated versus non-elevated group means was via *t*-tests; Bonferroni for multiple comparison adjusted critical *p* value for significance from 0.05 to 0.013 for each paired *t*-test result.

Table 4. Prevalence rate comparisons for elevated Compass of Shame Scale (CoSS) scores between the groups

CoSS poles	Percent with T-scores \geq 65		χ^2
	Patients	Controls	
Withdrawal	35	15	7.89**
Attack self	27	7	10.27**
Attack other	16	4	5.31*
Avoidance	4	6	0.12

* $p < 0.01$. ** $p < 0.001$.

Note: p values for χ^2 based on Fisher's Exact Test.

$n = 34$), revealing a significant difference in their respective group averages in hypersexuality ($F[1,69] = 13.68, p < 0.0001$).

DISCUSSION

In comparing hypersexual patients to a college sample on indices of hypersexual behaviour and coping strategies associated with defending against shame, several significant differences emerged. Although it is not entirely surprising that the patient sample was significantly different from the college sample in the severity of their hypersexuality, it should be remembered that college-age young adults are often more sexually adventurous and make riskier sexual decisions than subjects drawn from a community sample (Chng & Moore, 1994; Paul, McManus, & Hayes, 2000). Thus, if a patient sample is significantly different from a college sample on a measure of hypersexual behaviour, they are significantly different from a population that is already known to exhibit elevated frequencies in their sexual practices.

A small portion (18%) of the college sample had elevated scores on the HBI (≥ 53). This prevalence rate seems high; however, others have observed that heterosexual college men who engage in more masturbation than relational sex tend to score higher on measures of sexual compulsivity (Dodge, Reece, Cole, & Sandfort, 2004) and the HBI is more specific in identifying such individuals because it does not contain items unique to relational sex as other measures do.

Several differences also emerged between the groups in coping strategies used to defend against shame. The patient sample showed greater tendencies of Withdrawal, Attack Self and Attack Other when compared with the college controls. These

tendencies were also evident in the categorical analysis, in which a large percentage of patients had clinically meaningful scores on the Withdrawal and Attack Self poles of the CoSS. These results suggest that hypersexual patients are aware of their shaming experiences (although they may not identify their negative feelings as shame) and seek to escape or detach from the source of the shame. Although it is unclear what strategies are specifically used to withdraw, the positive correlations with hypersexuality provide evidence in support of our hypothesis that sex is among the repertoire of behaviours that patients use to minimize the painful and negative experience induced by shame.

The Attack Other pole yielded significant differences between the groups, with hypersexual patients showing greater tendencies to project or transfer the negative message of shame to others. These patients likely feel a sense of brokenness, which is at the core of personality traits such as narcissism, and consequently lack the capacity to absorb any additional experiences that activate shame. These findings are consistent with clinical impressions that individuals who are threatened by shaming experiences resort to anger or rage in order to manipulate a situation or others from holding them accountable for their unhealthy choices, especially their sexual decisions.

Interestingly, these data did not provide support for significant differences between the groups on the tendencies of Avoidance on the CoSS. A closer examination of the action tendencies associated with this pole provided some clarity for this finding. First, endorsement of items on the Avoidance pole requires respondents to acknowledge their denial or their perception of shaming experiences as insignificant, and for many hypersexual patients, their experience of shame plays a prominent role in reorganizing their perceptions and behaviours of which they are keenly aware. Hypersexual patients often are unable to recruit cognitive resources to combat such negative messages and are much more likely to accept the shaming experience and feel demoralized (Adams & Robinson, 2001). The Avoidance subscale also had the lowest reliability in this study ($\alpha = 0.68$), which may have had a modest effect on the results. As we examined the items of the Avoidance pole, we identified one statement that reflects how many clinicians likely perceive patients using sex as an avoidant behaviour ('When I feel rejected by someone I soothe myself with distractions'), and this item was, in fact, the *only* item on the subscale that was endorsed significantly more by

the hypersexual patients than by the college controls ($p < 0.001$). This pattern is consistent with our theory that sex is used as a strategy to avoid the painful effects of shame. To a lesser degree, the tendency to use sex to cope with unpleasant feelings, such as shame, is also captured by a few items on the HBI Coping subscale, such as 'I turn to sexual activities when I experience unpleasant feelings' and 'Sex provides a way for me to deal with emotional pain I feel'. This subscale showed the highest correlation with the shame poles as noted in Table 2.

Despite significant differences between the patients and controls, it should be remembered that a portion of the patients did not exhibit any elevated scores across the CoSS poles. Although this portion of the patients had significantly lower scores on the HBI than their cohort with elevated CoSS pole scores, their group average on the HBI was still clinically elevated (mean = 69.5) well beyond the cut-off score of 53. This finding serves as a reminder that hypersexual patients are not a homogenous group and that generalizations about this population should be made with caution.

Relevance of Findings for Clinical Practice

The findings in this study provide clinicians with a number of insights about coping strategies used by hypersexual patients in defending against shame. The pragmatic implications for these findings, in our opinion, suggest the following considerations and interventions that might be useful when working with hypersexual patients in clinical practice:

1. Help patients identify the precipitating and perpetuating risk factors that are most likely to activate maladaptive shame (e.g., maintenance of irrational thoughts or beliefs, interpersonal sensitivity).
2. Help patients label the emotional experience of shame, including the use of some immediacy around moments in psychotherapy when shame is activated. For example, when a patient engages in self-critical or self-deprecating statements (e.g., 'I'm stupid'), a therapist can label this behaviour as a manifestation of shame and an attack-self strategy to cope with this negative emotion (Greenberg & Paivio, 1998, 1997).
3. Help patients increase emotional intelligence by doing such things as identifying primary emotions that might underlie shame, such as fear or sadness. Patients will also benefit from

learning ways to assess their core emotions and from learning what the need of a given feeling might be. For example, the affective experience of fear might need to be comforted or soothed, or it might need to feel reassured.

4. Help increase tolerance for unpleasant affective experiences so patients learn they can survive their challenging moments in life without having to engage in unhealthy sexual activities to escape their emotional discomfort. For example, mindfulness exercises and theoretical perspectives embodied in Acceptance and Commitment Therapy (e.g., Hayes & Strosahl, 2005; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) and Emotion Focused Therapy (e.g., Greenberg, 2002, 2004) could increase tolerance for emotionally painful experiences and decrease the use of ineffective strategies employed to defend against shame.
5. Help patients cultivate social support networks that provide affirming messages to the sense of self and encourage engagement rather than withdrawal from interpersonal experiences that might trigger shame.
6. Help patients cultivate cognitive flexibility where different perspectives can be recruited to counter their self-critical attacks and maladaptive strategies used to defend against shame.

Limitations

Despite a number of interesting findings, this study was limited in several ways. First, this study is correlational and therefore does not address whether the various CoSS pole elevations exert a causal or interactive effect on hypersexual behaviour. This study also possesses the limitations commonly associated with and found in studies in which self-report measures are used. It would have also been ideal to have methodology that incorporated clinician or observer-rater methodology.

Inferences about our findings beyond those listed in this study should be made with caution, in part because our sample consisted of only male subjects who were mostly heterosexual. We also did not screen for mental health disorders among the college sample, which could have affected the results. In addition, a more diverse ethnic representation among subjects in our sample would have been ideal.

Although this sample lacks patients with comorbid hypersexuality and substance-related disorders, which has been noted in other studies (Kafka

& Prentky, 1994), this dynamic afforded the opportunity to investigate hypersexuality while minimizing confounds that could provide alternative explanations for our results.

Future Research

There are several findings from this study that might prompt future research. In particular, further understanding about the precipitating and perpetuating risk factors associated with maladaptive shame would be beneficial. Ideally, studies of this nature in the future should take into consideration any psychopathology present in the clinical sample. Clinical or observer rating methods to assess hypersexual behaviour would also increase the validity classifying of hypersexual patients.

Outcome studies are also needed to determine what empirically supported treatments might be most effective when working with shame and hypersexuality. Currently, the domain of hypersexuality remains a largely uncharted field that welcomes research by inquisitive researchers, and multi-center studies across various geographic regions would be a particularly valuable contribution to the existing literature.

Conclusion

This study used the CoSS to investigate coping strategies used by hypersexual patients to defend against shame. A number of significant differences emerged between the hypersexual patient group and the controls, including elevated scores for the hypersexual group showing tendencies towards withdrawal, self attack and attacking others in defending against shame. The Avoidance pole of the CoSS was not significant, suggesting that hypersexual patients are consciously aware of the shaming messages in their life experiences. The data in this study provide evidence in support of the hypothesis that hypersexual patients may use sex to escape or detach from shaming experiences they encounter. Shame is a complex phenomenon and requires continued study in the literature, specifically among hypersexual populations. Clinicians working with hypersexuality will benefit from a deeper understanding of shame and the ways that individuals attempt to defend against its painful effects.

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