

Assessing Readiness to Change among Clients Seeking Help for Hypersexual Behavior

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Mental health professionals may erroneously assume that clients seeking help for hypersexual behavior are ready to begin working on their issues at the outset of treatment. Prochaska and DiClemente (e.g., 1983, 1984) proposed the transtheoretical model (TTM) stages of change to advance their belief that clients move through several stages when attempting to alter specific target behaviors. If a clinician gets ahead of a client by administering interventions that are improperly matched with the client's readiness to change, treatment may be prematurely terminated or high levels of resistance may be encountered during therapy. In this study, clients (N = 67) who were referred for treatment in a specialty outpatient clinic for hypersexual behavior completed the Sexual Compulsivity Scale (Kalichman et al., 1994; Kalichman & Rompa, 1995, 2001) and the Stages of Change Scale (McConaughy, DiClemente, Prochaska, & Velicer, 1989; McConaughy, Prochaska, & Velicer, 1983). The data collected from these measures revealed that 70% (n = 47) of clients who expressed an interest in receiving help with issues related to hypersexuality also had high levels of ambivalence about the changes they desired to make and that individuals with ADHD were significantly (chi-square, $p \leq .001$) more likely to be in the contemplation stage than subjects presenting with alternative diagnoses. Implications for these findings are discussed and suggestions for future research are offered.

Mental health professionals may erroneously assume that clients seeking help for hypersexual behavior are ready to begin working on their issues at the outset of treatment. Prochaska, DiClemente, and colleagues (McConaughy, DiClemente, Prochaska, & Velicer, 1989; McConaughy, Prochaska, & Velicer,

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1983; Prochaska & DiClemente, 1983, 1984) proposed the transtheoretical model (TTM) stages of change to advance their belief that clients move through several stages of change when attempting to alter specific target behaviors. If a clinician gets ahead of a client by administering interventions improperly matched with the client's readiness to change, treatment may be prematurely terminated or high levels of resistance may be encountered during therapy (Brogan, Prochaska, & Prochaska, 1999; Moyers & Rollnick, 2002).

It is common knowledge that individuals with addictive behaviors have high attrition rates in therapy and that many who do enter treatment are resistant to therapeutic direction. In exploring these characteristics, researchers sought to determine if client readiness to change was related to outcomes in psychotherapy. Reports from such research suggest that despite intentions to change, the majority of clients struggling to abandon addictive behavior are ambivalent about making such changes or feel no need to change (Prochaska, DiClemente, & Norcross, 1992). Subsequently, it became important for clinicians working with addictions to address issues of motivation for change with their clients before developing treatment plans targeting behavior modification. Although some have inferred that results from TTM studies related to addictive behaviors can be generalized to individuals with hypersexual behaviors, the empirical research conducted thus far appears to be limited to studies exploring compliance with contraception use for individuals at high risk for sexually transmitted diseases or unintended pregnancies (e.g., Galavotti et al., 1995; Grimley, Prochaska, & Prochaska, 1993; LaBrie, Quinlan, Earltwine, & Schiffman, 2005; Stark et al., 1998).

The present study sought to determine if findings from other TTM studies related to various addictive behaviors can be generalized to individuals attempting to regulate or eliminate hypersexual behavior. Prochaska and colleagues (1994) postulate that a theoretical understanding of their model of change can be advantageous when working with individuals who engage in HIV-risk behavior, and findings from a study seeking to validate this assertion reported that the majority of individuals at high risk for contracting a sexually transmitted disease from unprotected sex were *not* ready to change (Harlow et al., 1999). Despite these findings, questions about readiness to change across several aspects of hypersexual behavior remain unanswered. This study investigates individuals presenting with problems related to several hypersexual behaviors and seeks to determine if they are ready to change at the outset of treatment and whether their change stage varies with the severity of their hypersexual behavior.

HYPERSEXUALITY

Hypersexuality is a phenomenon that is gradually gaining wider acceptance among mental health professionals. Elsewhere in the social science literature,

a vast array of terminology has been used to examine the phenomenon of hypersexual behavior, including labels such as *sexual impulsivity*, *sexual compulsivity*, *sexual addiction*, *sexual dependence*, *unrestrained sexual desire*, *sexual disinhibition*, *hypersexuality*, *sexual torridity*, *sexual sensation seeking*, *sexual desire disorders*, *excessive sexual desire disorder*, *hyperlibido*, *hyperactive sexual behavior*, *uninhibited sexual desire*, *paraphilia-related disorders*, *non-paraphilic sexual disorders*, *Don Juanism*, *erotomania*, *nymphomania*, and *satyriasis*.

Although some differences exist among the various theoretical constructs of hypersexuality, many researchers agree that symptoms include behavior dysregulation, impaired functioning, maladaptive coping skills, and incongruence with one's values and beliefs. Accordingly, the investigator operationally defines hypersexuality as a:

difficulty in regulating (e.g., diminishing or inhibiting) sexual thoughts, feelings, or behavior to the extent that negative consequences are experienced by the self or others. The behavior causes significant levels of personal or interpersonal distress and may include activities that are incongruent with personal values, beliefs, or desired goals. The behavior may function as a maladaptive coping mechanism (e.g., used to avoid emotional pain or used as a tension-reduction activity) and may coincide with other psychopathology or neurological impairments (Reid & Woolley, 2006, p. 220).

Because the construct of hypersexuality continues to fluctuate across the literature, this definition is considered a working description of the phenomena being studied in this investigation.

Associated Features of Hypersexual Behaviors

There is a vast constellation of problems associated with clients seeking help for hypersexual behavior. Health risks related to unprotected anonymous sex or to other risky sexual behavior, including extreme acts such as autoerotic asphyxiation, may be present. Functional impairments such as attachment ruptures in interpersonal relationships may coexist with sexual practices, and in some cases individuals have suffered severe economic losses such as termination of employment due to violation of corporate policies (e.g., consuming Internet pornography in the workplace). Legal problems can emerge when individuals cross boundaries established by cultural norms (e.g., solicitation of commercial sex workers). Compounding matters, clients often report a multitude of maladaptive emotions, including shame, loneliness, and hopelessness, which they sometimes seek to escape through sexually acting out. Despite the multitude of undesirable consequences associated with

hypersexuality, many report feeling trapped or discouraged after having made multiple unsuccessful attempts to regulate their sexual behavior.

Complicating the clinical picture, psychopathology is often present in this population with comorbidity issues such as substance-related disorders, anxiety disorders, mood disorders, and adult attention deficit disorders (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998; Raymond, Coleman, & Miner, 2003).

Although underlying issues of psychopathology may eventually become the focus of treatment, at the outset of therapy many clients seek symptom relief for consequences related to their sexual behavior. Interestingly, when therapists offer interventions for addressing these problems, reports of resistance and premature termination begin to surface. Since these same behavioral patterns have been observed in other populations (Brogan et al., 1999) and have been correlated with motivational deficits from unresolved ambivalence, the present study was designed to explore whether clients with hypersexual behavior exhibit similar characteristics. In order to examine this question, the stages of change model was used to provide a context for exploring readiness to change.

STAGES OF CHANGE

The stages of change were initially conceptualized in research conducted with patients seeking help for smoking cessation. In their transtheoretical model (TTM) of change, Prochaska and DiClemente (1983, 1984) proposed that *decisional balance*, as noted in the work of Janis and Mann (1977), and *self-efficacy*, derived from Bandura's social-cognitive theory (1997), were the primary factors that predicted an individual's ability to transition through various stages of change. Decisional balance refers to the process of cognitively appraising the benefits and costs associated with behavior modification. Self-efficacy refers to an individual's self-perceived confidence in his or her ability to make change occur. The TTM also operationalized several strategies individuals use to progress through stages or prevent regression during the change process.

A substantial body of research supporting the TTM exists and has been applied to a variety of behavior modification treatments. It appears helpful for predicting attitudes, outcomes, and attrition rates for clients seeking to change targeted concerns including smoking cessation (Prochaska & DiClemente, 1986; Prochaska, Velicer, & Guadagnoli, 1991), dietary behaviors and weight loss (O'Connell & Velicer, 1988; Povey, Conner, Sparks, James, & Shepherd, 1999; Rossi, Rossi, Velicer, & Prochaska, 1995), bulimia nervosa (Levy, 1997), exercise behavior (Burn, Naylor, & Page, 1999; Marcus et al., 1998; Nigg & Courneya, 1998; Peterson & Aldana, 1999), some sexual behaviors and

practices (Grimley et al., 1993; LaBrie et al., 2005) and substance abuse (Al-Otaibi, 1999).

The foundation supporting the TTM became translated into several stages of change that were theorized to embody the process by which individuals modified their behavior. These stages illuminate the constellation of attitudes and beliefs that characterize clients seeking to change various behaviors.

Definitions of Stages

The first stage, *precontemplation*, describes individuals who lack awareness of the need for change or are resigned to a belief that change is unlikely (e.g., they feel hopeless about their ability to change). Family, friends, and loved ones of precontemplators often recognize that problems exist and in some cases are the catalysts for these individuals when they present for therapy. Items on the Stages of Change Scale (SCS-C) that identify precontemplators include “I guess I have faults, but there’s nothing that I really need to change” and “As far as I’m concerned, I don’t have any problems that need changing.”

The second stage, *contemplation*, is characterized by individuals who are aware of a serious need for change and are considering modifying their behavior but have not translated those thoughts into actions. The hallmark of the contemplation stage is ambivalence about change. Even though contemplators may feel frustrated about their lack of motivation to change, one report (Prochaska & DiClemente, 1983) discovered that some individuals in this group remained in this stage for over two years. SCS-C items that assess contemplation include “I think I might be ready for some self-improvement” and “I wish I had more ideas on how to solve my problem.”

Two important characteristics of contemplators are their diminished capacity to assign positive evaluations to addictive behavior and their inability to assess the energy, effort, and loss that overcoming their behaviors will require (DiClemente, 1991; Prochaska & DiClemente, 1992; Velicer, DiClemente, Prochaska, & Brandenburg, 1985).

The third stage, *preparation*, describes people who have made some small attempts at change but have not embraced everything necessary to make change occur. These individuals plan to take action in the very near future. Although the preparation stage was not included in the initial stages of change, subsequent examination of the data supported adding it to the original four stages, making a total of five stages. On the SCS-C, preparation is measured by equally high scores on contemplation and action scales.

The fourth stage, *action*, characterizes individuals who are actively engaged in modifying their behavior. People committed to action are sacrificing the time, energy, and effort necessary for effective changes in their lives. Changes in this stage are often most visible to the outside observer and

therefore receive the most recognition and reinforcement by others. Action items on the SCS-C include “I am really working hard to change” and “Anyone can talk about changing; I’m actually doing something about it.”

The fifth stage, *maintenance*, is characterized by energy and effort devoted to relapse prevention. Gains made during the action stage are consolidated during this stage, and it is plausible that individuals will remain in this stage indefinitely as they continue to minimize their risk factors and manage their vulnerabilities. Maintenance items on the SCS-C include “I may need a boost right now to help me maintain the changes I’ve already made” and “I’m not following through with what I had already changed as well as I had hoped, and I’m here to prevent a relapse of the problem.”

It is important to note that clients do not usually transition through the stages in a sequential order. For example, individuals may vacillate between action and contemplation. Skilled therapists will continually monitor the process of change and will address motivational issues as a regular part of treatment when they arise.

In the present study, the hypothesis of the investigator predicted that the majority of clients seeking help for hypersexuality would be ambivalent about change and categorized as contemplators.

METHOD

Participants

The sample used in this study consisted of 67 male clients recruited from an outpatient clinic that specialized in the treatment of hypersexuality. These men were selected consecutively based on their chief complaint during intake and assessment. Clients received no incentives to participate in treatment, and all subjects in the study signed informed consent. No services or opportunities for psychological testing were denied clients who chose not to participate, and clients were free to withdraw from the study at any time. Of the clients invited to participate, 2 elected not to participate in the study and 4 subjects were eliminated from the original sample because their scores on the Sexual Compulsivity Scale (Kalichman et al, 1994; Kalichman & Rompa, 1995, 2001) were substantially below the cut-off score of 21 used in this study (88% of subjects had a score of 24 or more). Additional exclusion criteria included the presence of any psychotic symptoms, traumatic brain injury, or current psychoactive substance abuse in the last 30 days. Ethnic representation among the sample included Hispanic (5% or $n = 3$) and Caucasian (95% or $n = 64$) subjects, and participants ranged from 18 to 58 years of age. All participants reported heterosexual preferences. Additional demographic data on the participants are located in Table 1.

Self-reported presenting problems associated with sexual behavior among participants included compulsive masturbation (88%), excessive

TABLE 1 Demographic Data of Participants

<i>n</i> (% of sample)		<i>n</i> (% of sample)	
Ethnicity		Relationship Status	
Caucasian	64 (95.5)	Never married	21 (31.3)
Hispanic	3 (4.5)	First marriage	36 (53.7)
Age (<i>M</i> = 32.6, <i>SD</i> = 9.9)		Divorced	5 (7.5)
18–24 yrs.	14 (20.9)	Remarried	5 (7.5)
25–30 yrs.	23 (34.3)	Employment	
31–40 yrs.	16 (23.9)	Unemployed	2 (2.9)
41–58 yrs.	14 (20.9)	Part-time	9 (13.4)
Income		Full-time	47 (70.1)
\$0–15,999	17 (25.4)	Student	9 (13.4)
\$16,000–24,999	11 (16.4)	Referral Source	
\$25,000–35,999	8 (11.9)	Self	40 (59.7)
\$36,000–49,999	11 (16.4)	Family member	11 (16.4)
\$50,000–65,999	7 (10.4)	Therapist	3 (4.5)
\$66,000–79,999	3 (4.5)	Legal system	2 (2.9)
\$80,000–99,999	2 (2.9)	Religious leader	11 (16.4)
\$100,000 +	8 (11.9)	Sexual Preference	
		Heterosexual	67 (100)

pornography consumption (66%), voyeurism (2%), exhibitionism (2%), transvestic fetishism (2%), solicitation of commercial sex workers (14%), extra-marital affairs (13%), and unprotected sex with multiple partners (18%).

Measures

Because the scales used in this study have the same abbreviation (SCS), they will be differentiated by a fourth letter. The abbreviations are as follows: the Sexual Compulsivity Scale (SCS-S) and the Stages of Change Scale (SCS-C).

DEMOGRAPHIC QUESTIONNAIRE

Participants provided information related to their age, gender, income, ethnicity, sexual orientation or identity, education, employment status, religious preference, current medication, and source of referral.

SEXUAL COMPULSIVITY SCALE (SCS-S)

The SCS-S (Kalichman et al., 1994; Kalichman & Rompa, 1995, 2001) was developed to assist in research of high-risk sexual behaviors predominantly among gay male subjects, although it has since been used in several studies of both heterosexual and homosexual populations (Cooper, Delmonico, & Burg, 2000; Dodge, Reece, Cole, Sandfort, & Theo, 2004; Kalichman & Rompa, 1995, 2001; Reece & Dodge, 2004; Reece, Plate, & Daughtry, 2001).

The SCS-S is a 10-item Likert-type scale that queries sexual thoughts, feelings, and behaviors. Respondents endorse items on a 4-point scale ranging from 1 (not at all like me) to 4 (very much like me). High reliability ($\alpha = .89$) was demonstrated in a pilot convenience sample of homosexual men (Kalichman et al., 1994), and internal consistency for the scale has been shown from $\alpha = .86$ to $\alpha = .87$ with a sample of gay men and inner-city men and women, respectively (Kalichman & Rompa, 1995). The scale data in this study yielded acceptable reliability ($\alpha = .74$). Research using this scale has generally reported scores based on the mean of the sum of item scores, yielding a value between 1 and 4. Other studies have used a summed score method reporting values between 10 and 40. In cases where studies combined data from multiple sources, summed scores are divided by 10 for consistency.

STAGES OF CHANGE SCALE (SCS-C)

The SCS-C (also known as University of Rhode Island Change Assessment) was developed to embody change as conceptualized by Prochaska and DiClemente (1983). The SCS-C is a 32-item measure with four 8-item subscales: preparation, contemplation, action, and maintenance (McConaughy et al., 1983). Each of the Likert-type scale items requires a respondent's endorsement ranging from 1 (strongly disagree) to 5 (strongly agree). Internal consistency reliability coefficients for the four subscales range from .79 to .89 (McConaughy et al., 1983). Research has supported the construct validity of the stages of change model in a variety of populations and across a broad range of presenting problems (DiClemente et al., 1991).

Procedure

Clients who were seeking help in an outpatient clinic and whose chief complaint was related to hypersexual behavior were given a demographic questionnaire, informed consent, the SCS-S, and the SCS-C as part of the intake and assessment paperwork. These items were administered as part of routine assessment at the clinic and were used as part of clinical treatment. Clients were instructed to endorse items on the SCS-C related to their hypersexual behavior. These measures were subsequently given to their primary therapist, who discussed the results with the clients during their initial assessment interview.

Participants in this study were subject to a strict standard of assessment and diagnosis that combined a clinical interview of two separate clinicians (one a prescribing medical provider with psychiatric experience) and data collected from empirically supported objective measures including the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). In the cases where a possible diagnosis of ADHD was considered, three separate rating scales

were administered (*Conner's Adult ADHD Rating Scale-Long Form*, the *Adult ADHD Rating Scale*, and the *Wender Utah Rating Scale, 61-item version*). The *Wender Utah Rating Scale* was given to clients as a retroactive rating scale of childhood symptoms of ADHD. In many cases where ADHD was diagnosed, collateral data were also collected (e.g., observer ratings from spouses or parents, review of academic records) to validate self-reported symptoms of ADHD. Medical evaluations were also conducted to eliminate alternative explanations for ADHD symptoms. This standard of care was taken to avoid common methodological deficits in ADHD studies, such as lack of collateral information, unreliable measures, rater bias, and exclusions of medical history that might otherwise account for attention-deficit symptoms.

Data Analysis

Data collected from the measures was keyed into a database and double checked to verify accuracy of data entry. Computations of the data in this study included simple correlation matrixes to determine if there were any associations between SCS-S scores, psychopathology, demographic data, and stages of change. Additional analyses were conducted with subjects categorized as contemplators to determine whether higher SCS-S scores were associated with higher contemplation scores. A chi-square analysis was conducted to determine if any psychopathology was represented among the contemplators in a greater frequency than what would be expected. Descriptive statistics were conducted and analyzed to determine comparisons between the categorical data and percentage rates.

RESULTS AND DISCUSSION

Results

The prediction that the majority of clients seeking help for hypersexual behavior would be ambivalent about the changes they desired to make was confirmed with 70% ($n = 47$) falling in the contemplation stage, 19% ($n = 13$) in the preparation stage, and 11% ($n = 7$) in the action stage. The sample did not have any representation in either the maintenance or the precontemplation stages. No associations were found between levels of hypersexuality (mean score on the SCS-S was 2.66, $SD = .36$ or alternatively the summed score mean was 26.64, $SD = 3.64$) and stage of change, nor were there any correlations between SCS-S scores and scores within the contemplation stage. Additionally, demographic characteristics of participants did not appear to account for any of the variance associated with placement in a particular stage of change.

The presence of psychopathology among participants included mood disorders 59% ($n = 40$), anxiety disorders 21% ($n = 14$), attention-deficit

TABLE 2 Axis I Disorders of Participants, Sexual Compulsivity Scale (SCS-S) Means, and Placement in Stage of Change. CONT = Contemplation, PREP = Preparation, and ACT = Action

	<i>n</i> (% of sample ¹)	<i>n</i> (% of sample within disorder)			
		Means	SCS-S	CONT	PREP
Mood Disorders	40 (59.7)	2.64	28 (70)	9 (22.5)	3 (7.5)
Depression	13 (19.4)	2.75	11 (84.6)	1 (7.7)	1 (7.7)
Dysthymia	25 (37.3)	2.55	16 (64)	7 (28)	2 (8)
Bipolar	2 (2.9)	3.10	1 (50)	1 (50)	0 (0)
Anxiety Disorders	14 (20.8)	2.66	10 (71.4)	3 (21.4)	1 (7.1)
Generalized Anxiety	9 (13.4)	2.73	6 (66.6)	3 (33.3)	0 (0)
Social Phobia	5 (7.5)	2.52	4 (80)	0 (0)	1 (20)
Attention Deficit Disorders	18 (26.7) ²	2.82	15 (83.3)	1 (5.55)	2 (11.1)
Inattentive type	13 (19.4)	2.85	12 (92.3)	0 (0)	1 (7.7)
Combined type	5 (7.5)	2.74	3 (60)	1 (20)	2 (40)
Sexual and Gender	5 (7.5)	2.84	4 (80)	1 (20)	0 (0)
Exhibitionism	1 (1.5)	2.40	1 (100)	0 (0)	0 (0)
Voyeurism	2 (3)	2.50	1 (50)	1 (50)	0 (0)
Transvestic Fetishism	2 (3)	3.40	2 (100)	0 (0)	0 (0)
Substance Related	2 (3)	2.40	1 (50)	0 (0)	1 (50)
Substance Abuse	2 (3)	2.40	1 (50)	0 (0)	1 (50)
Impulse Control NOS ³	8 (12)	2.54	6 (75)	1 (12.5)	1 (12.5)

Table 2 Primary diagnosis of participants at time of initial assessment; totals may exceed sample size since prevalence rates include comorbidity among subjects. Table includes Axis I disorders only.

¹Percentage of entire subject pool (67 participants) is rounded to 1 decimal.

²ADHD diagnosis was made only after subjects completed the Adult ADHD Self-Report Scale, the Wender Utah Rating Scale for retroactive endorsement of ADHD symptoms, and the Conner's Adult ADHD Rating Scale—Long Form. These subjects were also given a clinical interview for ADHD, and the initial diagnosis by the primary therapist was confirmed by a second evaluation administered by a psychiatrist or a licensed Advanced Practice Registered Nurse.

³The 8 subjects diagnosed with Impulse Control NOS all appeared to be functioning well in most aspects of their lives. These participants did not meet the full criteria for any other Axis I diagnosis and were subsequently placed in this category. Almost all of the entire sample in this study could have been given a diagnosis of Impulse Control NOS (or similarly Sexual Disorder NOS), however, this diagnosis would not have provided any meaningful interpretation of psychopathology. The category of Impulse Control NOS was reserved exclusively for individuals who did not meet diagnostic criteria for any other Axis I disorder.

disorders 27% ($n = 18$), sexual and gender identity disorders 8% ($n = 5$), substance-related disorders 3% ($n = 2$), and disorders of impulse control not otherwise specified 12% ($n = 8$). Additional data on disorder subtypes is located in Table 2. The psychopathology represented in this sample is somewhat similar to that of other studies (Black et al., 1997; Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998; Raymond et al., 2003), with significant differences in prevalence rates of substance-related disorders.

Psychopathology among the contemplation stage produced a significantly greater representation of frequencies with ADHD than what would normally be expected χ^2 ($df = 6$, $n = 27.6$, $p \leq .001$). Participants with attention-deficit disorders had the highest percentage of subjects in

contemplation, 83% ($n = 15$), followed by sexual and gender identity disorders, 80% ($n = 5$).

Discussion and Treatment Implications

The data in this study provide evidence that clients seeking help for hypersexual behavior are ambivalent about the changes they desire to make. This is an important finding as some clinicians may erroneously assume that clients' professed desires to change will directly translate to action. If therapists begin formulating treatment plans that target specific behavior modification strategies when clients are ambivalent about change, such interventions are likely to be improperly matched with the client's readiness to engage in change. Treatment interventions that assume clients are in the action stage when they are really in contemplation may contribute to premature termination or high levels of resistance during therapy. Empirical research supports tailoring the therapeutic alliance and treatment intervention to the appropriate stage of change in order to enhance the outcome (Prochaska & Norcross, 2001).

Additionally, there is some evidence that the type of interaction or change process a therapist implements with a client can significantly impact treatment outcomes. Thus, doing the right thing at the right time is related to successful transition through stages of change. For example, activating experiential processes facilitates successful stage transitions in contemplation and precontemplation stages, but these processes are contraindicated during action stage where shifting to behavioral strategies is more correlated with positive outcomes (Perz, DiClemente, & Carbonari, 1996).

One of the basic fundamental principles of the helping profession is to *begin where the client is*, and this approach necessitates exploring the client's readiness to change as part of the assessment process and throughout treatment. Indifference to this principle of respect for the client's position is likely to cause attachment ruptures in the therapeutic alliance during the early stages of therapy, when client ratings of the therapeutic relationship are more predictive of psychotherapy outcome than ratings taken later in the treatment process (Gomes-Schwartz, 1978; Hartley & Strupp, 1983; Luborsky, Cruts-Christoph, Alexander, Margolis, & Cohen, 1983; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). Thus it is imperative that therapists do not get ahead of their clients' readiness to change and risk diminishing the clients' confidence in the therapist's ability to understand and be empathic toward their position. Instead, therapists must work to provide a supportive environment where clients can explore their ambivalence about change and address fears or concerns they may have about abandoning maladaptive behaviors.

Because the majority of clients presenting for treatment related to hypersexual behavior appear to be in contemplation, it is important to understand the nature of contemplators and what therapeutic processes might enable

clients to move through the processes of change into the action and maintenance stages.

Contemplators are theorized to have high levels of ambivalence, and some have postulated that these individuals lack the necessary motivation to change. It would be important in the process of assessment to explore the function or source of any existing motivational deficits. For example, is motivation related to psychopathology (e.g., depression or attention-deficit related disorders), or do other factors more accurately explain issues related to motivation? Leahy (1999), for example, conceptualized motivation deficits as "strategic self-limitation," where therapists seek to produce behavior modification and clients are committed to avoiding risks that may result in further loss, mistakes, regret, or exhaustion of resources.

Another perspective about motivational issues comes from the literature related to self-determination theory (e.g., Deci & Ryan, 1991, 1995, 2000; Pelletier, Tuson, & Haddad, 1997; Ryan, 1995), which explores how internal and external relationships function within and between persons in various social contexts and environments. This theory involves curiosity about the type of environments that optimize human development and growth potential and thus help individuals engage in self-regulation, which moves them in the direction of personal well-being. Researchers in this domain have found empirical evidence supporting three human needs that cultivate growth tendencies. (Growth tendencies include motivation for optimal functioning, healthy adaptation, and integration.) They identify these needs as (1) the need for *competence* (Harter, 1978), (2) the need for *relatedness, attachment, connection* (Baumeister & Leary, 1995; Reis, 1994), and (3) the need for *autonomy* (deCharms, 1968; Deci, 1975).

Miller and Rollnick (2002) postulate that motivation is an *interpersonal* process produced through the interaction between people. They depart from traditional explanations that describe motivation as an internal process within a person or as phenomena associated with a state or trait. Motivational interviewing has emerged from their work regarding how clients successfully resolve ambivalence in psychotherapy. Motivational interviewing encourages therapists to be curious about how their interaction with a particular client may be affecting the client's beliefs and attitudes about change. If resistance to change is encountered, the *therapist* needs to change his or her way of interacting. Other principles of motivational interviewing include developing a collaborative relationship with clients in which (1) empathy can be expressed, (2) discrepancy can be developed, (3) therapists roll with resistance, and (4) client self-efficacy is supported (Miller & Rollnick, 2002; Moyers & Rollnick, 2002).

Therapists may want to evaluate how they conceptualize motivation and what techniques they will incorporate to address motivational issues in psychotherapy. Based on the findings of this study, client ambivalence about change will be the rule, not the exception. If ambivalence can be

successfully resolved and clients are able to develop clarity about the directions they wish to pursue, it is likely that compliance with treatment plans will be enhanced, resistance to change will be reduced, and attrition among clients will diminish. Subsequently, when clients seek help for hypersexual behavior, clinicians will want to begin by exploring reasons an individual wants to change. Other questions may include exploring the client's beliefs about the benefits and costs associated with change: How do they feel about potential incongruence between their professed beliefs and their behavior? Is there discrepancy between sexual behavior and values? Is their motivation to change internal or externally regulated? What would happen in six months if nothing were done?

Another facet of change that must be evaluated is the extent to which a therapist's beliefs and values may impact objectivity in psychotherapy. Undoubtedly, there are certain instances where a therapist will want to impose his or her personal bias on a particular client (e.g., when a client has suicidal intentions). But what about less obvious manifestations of client behavior that could result in self-harm, such as unprotected sexual encounters with multiple anonymous partners? How is client ambivalence about changing risky sexual behavior addressed in psychotherapy? Are these approaches different when a client has ambivalence about less severe behaviors that may cause personal distress or economic loss (e.g., pornography consumption in the workplace)? What are the therapist's beliefs about the pain and suffering that may emerge as a result of hypersexual behavior? For example, therapists who attempt to rescue clients from the consequences of their dysfunctional choices may remove the very pain that would facilitate adaptive changes. These are some important considerations that will influence the process of change in clients and contribute to possible resistance or collaboration in therapy.

In addition to the question about motivation to change, several other findings were particularly interesting in this study. These findings include higher elevated scores on the SCS-S compared to other studies, a lack of substance-related comorbidity in this sample, the absence of subjects in precontemplation or maintenance stages, and the high frequency of contemplators with ADHD. Each of these findings will be discussed briefly.

The absence of representation in the precontemplation and maintenance stages of change is somewhat rare. Although it is not unlikely that a sample may lack representation in the maintenance stage, it is rare that a sample will lack precontemplators. One explanation for this finding is that the majority of clients were self-referred for treatment and, based on clinician observations during assessment, appeared genuine and authentic in their desires to receive help. Many reported affiliation with religious values and beliefs that were supportive of their desires to modify their hypersexual behavior.

The elevated scores on the SCS-S represent another difference in this study compared to mean scores reported elsewhere (Dodge et al., 2004;

Reece & Dodge, 2004). This finding is especially interesting given that many of the participants in this study engaged in solo-sex behavior, and the SCS-S has items related to partner sex. It is possible that subjects seeking treatment wanted to communicate their need for help through over-endorsement of scale items. This subjective report may provide insight into participants' feelings about their perspectives, namely that they believed themselves to be sexually compulsive.

The investigator recognizes that the number of substance-related disorders diagnosed in this sample is small compared to the social science literature, which suggests prevalence rates of 40 to 64% among this population (e.g., Black et al., 1997; Kafka & Prentky, 1994). In explaining this discrepancy, it is important to note that the majority of clients in this study adhered to a religious health code prohibiting the use of tobacco, alcohol, and illegal drugs. Although not a focus of this study, it is noteworthy that this sample did not differ significantly across other domains of comorbidity found in individuals with hypersexual behavior (Black et al., 1997; Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998; Raymond et al., 2003) with the exception of less major depression and higher dysthymia percentages. The investigator believes that the higher prevalence of substance-related disorders in other samples exacerbates depressed mood states and subsequently causes dysthymic disorders to transition to major depression. Since this study had a paucity of substance-related disorders ($n = 2$), there was more dysthymia than major depression. Although this sample does not adequately represent clients with comorbid hypersexual behavior *and* substance-related disorders, the investigator considers this a strength of this study because the general absence of substance-related problems makes these participants a purer sample of the construct we are attempting to investigate, namely hypersexuality.

As observed in the results of this study, individuals with ADHD psychopathology are significantly more likely to be contemplative. Although not the focus of the current investigation, the presence of ADHD among clients with hypersexual behavior found in this study, 27% ($n = 18$), replicates findings in other research conducted with the population of interest (Blankenship & Laaser, 2004; Kafka & Prentky, 1998; Kafka & Hennen, 2002). Subsequently, the finding of the highest percentage of contemplators, 83% ($n = 15$), in the ADHD population in this study raises a vast array of questions. Interestingly, this rate increased when the subtype of ADHD with inattentive features was examined, revealing that 92% ($n = 12$) of subjects with an inattentive subtype were in the contemplation stage. It is possible that symptoms common in the clinical picture of ADHD, such as the inability to successfully make changes and the life pattern of failure to complete tasks or follow through on assignments, are being manifest in the contemplation stage and are not necessarily unique to the subjects' hypersexual behavior. Regardless, clinicians will want to be mindful that ADHD clients are less likely to be ready to

change when presenting for treatment related to hypersexual behavior, and this will especially be true if their subtype of ADHD is inattention.

Limitations

All of the subjects in this study were men, and results cannot be generalized with confidence to women seeking help for hypersexual behavior. The sample was also small ($N = 67$), heterosexual, and mostly Caucasian. More diversity of ethnicity, sexual preference, and other demographic variables would have been preferable. Subsequently, caution should be exercised when generalizing these results to groups underrepresented in this sample. Despite these shortcomings, the finding that the majority of individuals seeking treatment were not ready to change has been demonstrated in other studies using the stages of change model with clients who present for treatment with addictive-type behaviors.

As noted before, the investigator considers the deficit in substance-related disorders in this study an opportunity to explore more clearly the construct of hypersexuality; however, others may see this atypical characteristic of this sample a limitation.

Another limitation of this study is related to a recent development in measures exploring readiness for change that suggest three factors, not four, are psychometrically supported by the stages of change model. Miller and Tonigan (1996) report items loading on factors which they labeled *Taking Steps*, *Recognition*, and *Ambivalence* were more strongly supported in their analysis of a 19-item measure developed for individuals seeking help for alcohol abuse. Although this finding was specific to a substance abuse population, it nevertheless raises questions that could be the subject of future investigations. Regardless, the data in this study did not lend itself to exploring a three-factor solution; nevertheless, both conceptualization of stages of change includes a stage that captures and measures the construct of ambivalence which was the focus of interest in the current investigation.

Additional Research

The investigator is of the opinion that use of the SCS-C in clinical work may have limited utility outside of research, as issues related to motivation and ambivalence about change can be best explored through effective interviewing rather than objective measures. In the case where objective measures are used, LaBrie et al. (2005) provided some evidence that alternative brief measures have similar reliability and validity compared with longer readiness to change questionnaires. Future research might focus on the need to understand the decision-making process across the stages of change. Some

work has been done in this area (Prochaska, Velicer, et al., 1994), but a paucity of research exists for hypersexual behavior. In particular, investigators might consider exploring the impact of client self-efficacy and motivation on treatment outcome for hypersexual behavior, including existing styles of intervention for contemplators such as motivational interviewing.

Another avenue of future research might explore how psychopathology impacts readiness to change in individuals with hypersexual behavior, with a possible emphasis on clients diagnosed with ADHD. Future research might explore empirically validated explanations for this finding. Does ADHD impair clients' motivation to modify hypersexual behavior? Is there a relationship between ADHD and levels of ambivalence, and what factors account for any associations? Are there special considerations unique to ADHD populations that clinicians should consider when assessing readiness to change?

CONCLUSION

This study sought to investigate readiness to change among clients presenting with hypersexual behavior and also to increase awareness about the stages of change for mental health professionals treating this population. Evidence from the findings in this study suggest that the majority of clients seeking help have ambivalence about change and that this will more likely be true for clients diagnosed with ADHD. Clinicians should carefully assess motivation and readiness to engage in behavior modification at the outset of treatment and appropriately tailor interventions to each client's stage of change in order to increase the likelihood of positive outcomes in treatment.

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